

**THE ROMAN CATHOLIC  
ARCHDIOCESE OF ATLANTA**

**GROUP HEALTH CARE PLAN**

Effective: January 1, 2005

Restated: January 1, 2011

Group No.: 10974

**AMENDMENT #1**  
**to the**  
**THE ROMAN CATHOLIC ARCHDIOCESE OF ATLANTA**  
**GROUP HEALTH CARE PLAN**  
**Group No. 10974**

This Amendment describes changes to The Roman Catholic Archdiocese of Atlanta Group Health Care Plan effective January 1, 2011. **These changes are effective as of January 1, 2011** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document. Please contact the Plan Administrator identified in the Plan Document if you have any questions regarding the changes described in this Amendment.

The Roman Catholic Archdiocese of Atlanta (the "Plan Administrator") is amending the The Roman Catholic Archdiocese of Atlanta Group Health Care Plan (the "Plan") as follows:

The "Physician Office Visits" and "Routine Care" benefits in the *Schedule of Medical Benefits – Value Plan* are hereby deleted and replaced with the following:

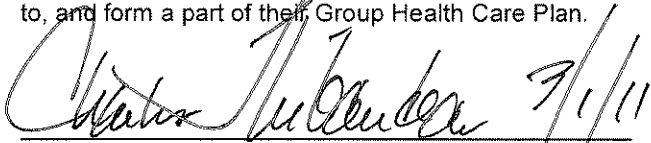
<b>SCHEDULE OF MEDICAL BENEFITS VALUE PLAN</b>				
<b>MEDICAL BENEFITS</b>	<b>PPO PROVIDERS</b>		<b>NON-PPO PROVIDERS (Subject to Usual &amp; Customary Charges)</b>	
	<b>Plan Pays</b>	<b>Covered Person Pays</b>	<b>Plan Pays</b>	<b>Covered Person Pays</b>
<i>Physician Office Visits</i>	100%	\$25 Co-pay; Deductible waived	60%	40% after Deductible
X-ray and Lab Services Performed in a Physician's Office	100%	\$0	60%	40% after Deductible
<i>Routine Care</i> (age 17 and over)	100%	\$25 Co-pay; Deductible waived	No Coverage	N/A
X-ray and Lab Services Performed in a Physician's Office	100%	\$0		

The "Physician Office Visits" and "Routine Care" benefits in the **Schedule of Medical Benefits – Premier Plan** are hereby deleted and replaced with the following:

SCHEDULE OF MEDICAL BENEFITS PREMIER PLAN				
MEDICAL BENEFITS	PPO PROVIDERS		NON-PPO PROVIDERS (Subject to Usual & Customary Charges)	
	Plan Pays	Covered Person Pays	Plan Pays	Covered Person Pays
<b>Physician Office Visits</b>	100%	\$20 Co-pay; Deductible waived	70%	30% after Deductible
X-ray and Lab Services Performed in a Physician's Office	100%	\$0	70%	30% after Deductible
<b>Routine Care</b> (age 17 and over)	100%	\$20 Co-pay; Deductible waived	No Coverage	N/A
X-ray and Lab Services Performed in a Physician's Office	100%	\$0		

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, The Roman Catholic Archdiocese of Atlanta has caused this Amendment to take effect, be attached to, and form a part of their Group Health Care Plan.

  
 Authorized Signature \_\_\_\_\_ Date 7/1/11

  
 Title \_\_\_\_\_

  
 Witness \_\_\_\_\_ Date 3-1-2011

  
 Title \_\_\_\_\_

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## GENERAL INFORMATION

The Roman Catholic Archdiocese of Atlanta Employee Benefit Plan believes it is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the “Affordable Care Act”). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 680 West Peachtree Street N.W. Atlanta, GA 30308-1984. You may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov).

**Name of Plan:** The Roman Catholic Archdiocese of Atlanta  
Group Health Care Plan

**Plan Administrator:** The Roman Catholic Archdiocese of Atlanta  
680 West Peachtree Street N.W.  
Atlanta, GA 30308-1984

**Group Number:** 10974

**Employer Tax ID Number:** 58-0677170

**Plan Effective Date:** January 1, 2005  
Plan Restated Date: January 1, 2011

**Plan Renewal Date:** January 1

**Plan Year Ends:** December 31

**Contract Administrator:** Meritain Health<sup>SM</sup>  
P.O. Box 27267  
Minneapolis, MN 55427-0267  
(952) 546-0062  
(800) 925-2272

**Effective Date of Coverage:** See **Eligibility & Enrollment** section.

**Termination Date of Coverage:** The date of termination.

**IMPORTANT:** Meritain Health<sup>sm</sup> Medical Management must pre-certify all acute Inpatient stays (including acute Inpatient rehabilitation and subacute care provided in a facility that has nursing staff on-site 24 hours a day, 7 days a week, and a Physician on call 24 hours a day, 7 days a week), and all Chemotherapy and Radiation Therapy Treatment. See **Medical Management** section of the Plan for details on Pre-Certification. If these procedures are not followed, eligible expenses will be reduced by \$500 per occurrence, per individual.

<b>SCHEDULE OF MEDICAL BENEFITS VALUE PLAN</b>				
	<b>PPO PROVIDERS</b>		<b>NON-PPO PROVIDERS (Subject to Usual &amp; Customary Charges)</b>	
<b>OVERALL LIFETIME MAXIMUM BENEFIT</b>	Unlimited			
<b>OVERALL CALENDAR YEAR MAXIMUM BENEFIT</b>	\$3,000,000			
<b>CALENDAR YEAR DEDUCTIBLE</b>				
Individual			\$400	
Family			\$1,200	
<b>CALENDAR YEAR OUT-OF-POCKET LIMIT (does not include Deductibles)</b>				
Individual	\$2,000		\$3,500	
Family	\$4,000		\$7,000	
The Deductible amounts and the lifetime maximum amounts are combined for PPO and Non-PPO Providers, however, the Out-of-Pocket Limit amounts for PPO Providers and Non-PPO Providers are separate amounts and do not integrate.				
Expenses incurred for the following cannot be applied toward the Out-of-Pocket Limit: (1) Co-pays; (2) Deductibles; (3) any penalty amounts; and (4) any charges as defined in the <b>General Exclusions and Limitations</b> section.				
	<b>PPO PROVIDERS</b>		<b>NON-PPO PROVIDERS (Subject to Usual &amp; Customary Charges)</b>	
<b>MEDICAL BENEFITS</b>	<b>Plan Pays</b>	<b>Covered Person Pays</b>	<b>Plan Pays</b>	<b>Covered Person Pays</b>
<b>Allergy Services</b>	100% after Co-pay	\$25 Co-pay; Deductible waived (Part of Physician Office Visit benefit)	60%	40% after Deductible
<b>Ambulance Services</b>	80%	20% after Deductible	80%	20% after Deductible; subject to PPO Out-of-Pocket Limits
<b>Chiropractic Care</b>	100%	\$25 Co-pay; Deductible waived	60%	40% after Deductible
Calendar Year Maximum Benefit	20 visits		20 visits	
<b>Durable Medical Equipment</b>	80%	20% after Deductible	80%	20% after Deductible; subject to PPO Out-of-Pocket Limits
<b>Emergency Room</b>	80%	20% after Deductible	60%	40% after Deductible
<b>Extended Care Facility/ Rehabilitation Facility</b>	80%	20% after Deductible	80%	20% after Deductible; subject to PPO Out-of-Pocket Limits
<b>Home Health Care</b>	80%	20% after Deductible	60%	40% after Deductible
Calendar Year Maximum Benefit	120 visits		120 visits	
<b>Hospice Care</b>	80%	20% after Deductible	80%	20% after Deductible; subject to PPO Out-of-Pocket Limits

	PPO PROVIDERS		NON-PPO PROVIDERS (Subject to Usual & Customary Charges)	
MEDICAL BENEFITS	Plan Pays	Covered Person Pays	Plan Pays	Covered Person Pays
<b>Hospital Expenses</b> (facility charges)				
<u>Inpatient</u>	80%	20% after Deductible	60%	40% after Deductible
Room & Board Allowance	Semi-private room rate (private room when Medically Necessary)		Semi-private room rate (private room when Medically Necessary)	
Intensive Care Unit	Negotiated Fee	20% after Deductible	Negotiated Fee	40% after Deductible
Miscellaneous Services & Supplies	80%	20% after Deductible	60%	40% after Deductible
<u>Outpatient</u>	80%	20% after Deductible	60%	40% after Deductible
<b>Maternity</b>	80%	20% after Deductible	60%	40% after Deductible
<b>Mental Disorders</b>	Same as any other Illness	Same as any other Illness	Same as any other Illness	Same as any other Illness
<b>Outpatient Diagnostic Testing, X-ray and Laboratory Services</b>	80%	20% after Deductible	60%	40% after Deductible
<b>Outpatient Lab Card Services</b>	100%	N/A	N/A	N/A
The use of the Lab Card program offered by Quest Diagnostics is strictly voluntary. If a Covered Person uses the services of Lab Card, the Plan will pay 100% of the eligible charges a Covered Person incurs for outpatient laboratory services, and will waive any of this Plan's Co-pays, Deductibles and/or Co-insurance requirements. If a Covered Person and/or a Physician elect to use another lab – including the lab in the Physician's office, normal Plan benefits will apply. See the Diagnostic Testing, X-ray and Laboratory Services benefit under <b>Eligible Medical Expenses</b> for further details of this program.				
<b>Outpatient Therapies</b> (i.e. physical, speech, occupational)	80%	20% after Deductible	80%	20% after Deductible; subject to PPO Out-of-Pocket Limits
<b>Physician Office Visits</b>	100%	\$25 Co-pay; Deductible waived	60%	40% after Deductible
<b>Routine Cancer Screening</b> (see <b>Eligible Medical Expenses</b> for additional limits)	100%	N/A	No Coverage	N/A
<b>Routine Care</b> (age 17 and over)	100%	\$25 Co-pay; Deductible waived	No Coverage	N/A
<b>Routine Mammograms</b>	100%	N/A	No Coverage	N/A
<b>Routine Newborn Care</b> The first 30 days following birth (whether or not the newborn is enrolled as a dependent)	Paid under the mother's maternity benefit	Paid under the mother's maternity benefit	Paid under the mother's maternity benefit	Paid under the mother's maternity benefit
After 30 days following birth (only if dependent is enrolled)	80%	20% after Deductible	60%	40% after Deductible
<b>Smoking Cessation</b>	100% after Co-pay	\$25 Co-pay; Deductible waived	No Coverage	N/A
Calendar Year Maximum Benefit	1 program			

	PPO PROVIDERS		NON-PPO PROVIDERS (Subject to Usual & Customary Charges)	
MEDICAL BENEFITS	Plan Pays	Covered Person Pays	Plan Pays	Covered Person Pays
<b>Transplants Performed at an Aetna Institute of Excellence (IOE) Facility</b>	80%	20% after Deductible	N/A	N/A
<b>Transplants Performed at any Other Facility</b> (non-IOE facility - including a Par Aetna Facility not specified as an IOE facility)	N/A	N/A	60%	40% after Deductible
<b>Urgent Care Facility</b>	100%	\$25 Co-pay; Deductible waived	60%	40% after Deductible
<b>Vision Materials</b> (i.e. lenses, frames, contacts, etc.) Calendar Year Maximum Benefit	100% \$250	N/A	100% \$250	N/A
<b>Well Child Care</b> (up through age 16)	100%	\$25 Co-pay; Deductible waived	No Coverage	N/A
<b>Wig Due to Chemotherapy</b> Lifetime Maximum Benefit	80% 1 wig	20% after Deductible	60% 1 wig	40% after Deductible
<b>All Other Eligible Expenses</b>	80%	20% after Deductible	60%	40% after Deductible

**IMPORTANT:** Meritain Health<sup>sm</sup> Medical Management must pre-certify all acute Inpatient stays (including acute Inpatient rehabilitation and subacute care provided in a facility that has nursing staff on-site 24 hours a day, 7 days a week, and a Physician on call 24 hours a day, 7 days a week), and all Chemotherapy and Radiation Therapy Treatment. See **Medical Management** section of the Plan for details on Pre-Certification. If these procedures are not followed, eligible expenses will be reduced by \$500 per occurrence, per individual.

<b>SCHEDULE OF MEDICAL BENEFITS PREMIER PLAN</b>				
	<b>PPO PROVIDERS</b>		<b>NON-PPO PROVIDERS (Subject to Usual &amp; Customary Charges)</b>	
<b>OVERALL LIFETIME MAXIMUM BENEFIT</b>	Unlimited			
<b>OVERALL CALENDAR YEAR MAXIMUM BENEFIT</b>	\$3,000,000			
<b>CALENDAR YEAR DEDUCTIBLE</b>				
Individual			\$300	
Family			\$900	
<b>CALENDAR YEAR OUT-OF-POCKET LIMIT (does not include Deductibles)</b>				
Individual	\$1,500		\$2,500	
Family	\$3,000		\$5,000	
The Deductible amounts and the lifetime maximum amounts are combined for PPO and Non-PPO Providers, however, the Out-of-Pocket Limit amounts for PPO Providers and Non-PPO Providers are separate amounts and do not integrate.				
Expenses incurred for the following cannot be applied toward the Out-of-Pocket Limit: (1) Co-pays; (2) Deductibles; (3) any penalty amounts; and (4) any charges as defined in the <b>General Exclusions and Limitations</b> section.				
	<b>PPO PROVIDERS</b>		<b>NON-PPO PROVIDERS (Subject to Usual &amp; Customary Charges)</b>	
<b>MEDICAL BENEFITS</b>	<b>Plan Pays</b>	<b>Covered Person Pays</b>	<b>Plan Pays</b>	<b>Covered Person Pays</b>
<b>Allergy Services</b>	100% after Co-pay	\$20 Co-pay; Deductible waived (Part of Physician Office Visit benefit)	70%	30% after Deductible
<b>Ambulance Services</b>	90%	10% after Deductible	90%	10% after Deductible; subject to PPO Out-of-Pocket Limits
<b>Chiropractic Care</b>	100%	\$20 Co-pay; Deductible waived	70%	30% after Deductible
Calendar Year Maximum Benefit	20 visits		20 visits	
<b>Durable Medical Equipment</b>	90%	10% after Deductible	90%	10% after Deductible; subject to PPO Out-of-Pocket Limits
<b>Emergency Room</b>	90%	10% after Deductible	70%	30% after Deductible
<b>Extended Care Facility/ Rehabilitation Facility</b>	90%	10% after Deductible	90%	10% after Deductible; subject to PPO Out-of-Pocket Limits
<b>Home Health Care</b>	90%	10% after Deductible	70%	30% after Deductible
Calendar Year Maximum Benefit	120 visits		120 visits	
<b>Hospice Care</b>	90%	10% after Deductible	90%	10% after Deductible; subject to PPO Out-of-Pocket Limits

	PPO PROVIDERS		NON-PPO PROVIDERS (Subject to Usual & Customary Charges)	
MEDICAL BENEFITS	Plan Pays	Covered Person Pays	Plan Pays	Covered Person Pays
<b>Hospital Expenses</b> (facility charges) <u>Inpatient</u>	90%	10% after Deductible	70%	30% after Deductible
Room & Board Allowance	Semi-private room rate (private room when Medically Necessary)		Semi-private room rate (private room when Medically Necessary)	
Intensive Care Unit	Negotiated Fee	10% after Deductible	Negotiated Fee	30% after Deductible
Miscellaneous Services & Supplies	90%	10% after Deductible	70%	30% after Deductible
<u>Outpatient</u>	90%	10% after Deductible	70%	30% after Deductible
<b>Maternity</b>	90%	10% after Deductible	70%	30% after Deductible
<b>Mental Disorders</b>	Same as any other Illness	Same as any other Illness	Same as any other Illness	Same as any other Illness
<b>Outpatient Diagnostic Testing, X-ray and Laboratory Services</b>	90%	10% after Deductible	70%	30% after Deductible
<b>Outpatient Lab Card Services</b>	100%	N/A	N/A	N/A
The use of the Lab Card program offered by Quest Diagnostics is strictly voluntary. If a Covered Person uses the services of Lab Card, the Plan will pay 100% of the eligible charges a Covered Person incurs for outpatient laboratory services, and will waive any of this Plan's Co-pays, Deductibles and/or Co-insurance requirements. If a Covered Person and/or a Physician elect to use another lab – including the lab in the Physician's office, normal Plan benefits will apply. See the Diagnostic Testing, X-ray and Laboratory Services benefit under <b>Eligible Medical Expenses</b> for further details of this program.				
<b>Outpatient Therapies</b> (i.e. physical, speech, occupational)	90%	10% after Deductible	90%	10% after Deductible; subject to PPO Out-of-Pocket Limits
<b>Physician Office Visits</b>	100%	\$20 Co-pay; Deductible waived	70%	30% after Deductible
<b>Routine Cancer Screening</b>  (see <b>Eligible Medical Expenses</b> for additional limits)	100%	N/A	No Coverage	N/A
<b>Routine Care</b> (age 17 and over)	100%	\$20 Co-pay; Deductible waived	No Coverage	N/A
<b>Routine Mammograms</b>	100%	N/A	No Coverage	N/A
<b>Routine Newborn Care</b> The first 30 days following birth (whether or not the newborn is enrolled as a dependent)	Paid under the mother's maternity benefit	Paid under the mother's maternity benefit	Paid under the mother's maternity benefit	Paid under the mother's maternity benefit
After 30 days following birth (only if dependent is enrolled)	90%	10% after Deductible	70%	30% after Deductible
<b>Smoking Cessation</b>  Calendar Year Maximum Benefit	100% after Co-pay  1 program	\$20 Co-pay; Deductible waived	No Coverage	N/A

	PPO PROVIDERS		NON-PPO PROVIDERS (Subject to Usual & Customary Charges)	
MEDICAL BENEFITS	Plan Pays	Covered Person Pays	Plan Pays	Covered Person Pays
<b>Transplants Performed at an Aetna Institute of Excellence (IOE) Facility</b>	90%	10% after Deductible	N/A	N/A
<b>Transplants Performed at any Other Facility</b> (non-IOE facility - including a Par Aetna Facility not specified as an IOE facility)	N/A	N/A	70%	30% after Deductible
<b>Urgent Care Facility</b>	100%	\$20 Co-pay; Deductible waived	70%	30% after Deductible
<b>Vision Materials</b> (i.e. lenses, frames, contacts, etc.) Calendar Year Maximum Benefit	100% \$250	N/A	100% \$250	N/A
<b>Well Child Care</b> (up through age 16)	100%	\$20 Co-pay; Deductible waived	No Coverage	N/A
<b>Wig Due to Chemotherapy</b> Lifetime Maximum Benefit	90% 1 wig	10% after Deductible	70% 1 wig	30% after Deductible
<b>All Other Eligible Expenses</b>	90%	10% after Deductible	70%	30% after Deductible

## **BENEFIT PROVISIONS VALUE PLAN AND PREMIER PLAN**

A separate listing may be obtained from the Plan Administrator showing the providers available within the Preferred Provider Network at no cost to the Covered Person.

PPO Providers are not subject to Usual and Customary Charges. Non-PPO Providers are subject to Usual and Customary Charges and any charges in excess of Usual and Customary will not be considered eligible for payment.

Eligible expenses incurred by individuals who reside more than thirty (30) miles outside the PPO Network area will be paid at the PPO Provider level of benefits.

Professional services which are not available within thirty (30) miles of the PPO Network will be paid at the PPO Provider level of benefits.

Expenses which are incurred due to a Medical Emergency by a Non-PPO Provider will be paid at the PPO Provider level of benefits.

Medical supplies for which there is no network provider available will be paid at the PPO Provider level of benefits.

Individuals who are referred outside the PPO Network by a PPO Physician will have benefits paid at the PPO Provider level of benefits, subject to Usual and Customary Charges.

If a PPO Physician or PPO facility refers x-ray and laboratory services to a Non-PPO Provider, those services will be paid at the PPO Provider level of benefits.

Professional services which are provided by a Non-PPO Provider but rendered at a PPO facility will be paid at the PPO Provider level of benefits.

Non-PPO facility charges will be paid at the PPO level of benefits if the surgeon is/was a PPO Provider.

Expenses for obtaining medical records will be paid in full to a maximum benefit of \$100 per provider.

## PRESCRIPTION DRUG CARD BENEFITS

<b>Prescription Drug Card</b>	
Retail:	
Generic	\$10 Co-pay, then 100%
Brand Name	\$30 Co-pay, then 100%
Mail Order:	
Generic	\$20 Co-pay, then 100%
Brand Name	\$60 Co-pay, then 100%
Non-Network Pharmacy	No Coverage

### PRESCRIPTION DRUG CARD PROGRAM

Eligible drugs and medicines prescribed in writing by a Physician and dispensed by a licensed pharmacist, up to a thirty-four (34) day supply or one hundred (100) unit dose, whichever is greater, (90 day supply or 300 unit dose, whichever is greater, for mail order) which are deemed necessary for treatment of an Illness or Injury, including, but not limited to, insulin, diabetic supplies, and viagra.

Expenses for injectables that are not covered under the Prescription Drug Card program and are Medically Necessary for the treatment of a covered Illness or Injury will be payable under this Plan subject to any applicable major medical PPO Deductibles and Co-insurance.

**NOTE:** Coverage, limitations, and exclusions for prescription drugs will be determined through the Prescription Drug Card program elected by the Employer and will not be subject to any limitations and exclusions under the major medical plan. The Prescription Drug Card program is a separate benefit from the major medical plan. However, prescription drugs are subject to the Overall Lifetime Maximum Benefit shown in the **Schedule of Medical Benefits**.

## SCHEDULE OF DENTAL BENEFITS

	Plan Pays	Covered Person Pays (Subject to Usual & Customary Charges)
<b>CALENDAR YEAR DEDUCTIBLE</b> Per Individual	\$0	\$50
<b>DENTAL BENEFITS</b>		
<b>Class "A" Expenses</b> (Preventive Services)	100%	\$0
<b>Class "B" Expenses</b> (Basic Services)	80%	20% after Deductible
<b>Class "C" Expenses</b> (Major Services)	80%	20% after Deductible
<b>Class "D" Expenses</b> (Orthodontia)	80%	20% after Deductible
<b>CALENDAR YEAR MAXIMUM BENEFIT</b> (Classes "A", "B", "C", and "D" Expenses Combined per Person)		\$1,500

## **ELIGIBILITY & ENROLLMENT**

### **EMPLOYEES**

#### **A - ELIGIBLE EMPLOYEES**

##### **Priests, Religious and Seminarians:**

Priests, Religious and Seminarians who provide services to The Roman Catholic Archdiocese of Atlanta will be eligible to enroll for coverage under this Plan.

##### **Lay Employees:**

A full-time employee (including Deacons) who works a minimum of fifteen hundred (1500) hours annually will be eligible to enroll for coverage under this Plan. Other employees such as part-time, temporary, or seasonal will not be eligible to enroll for coverage under this Plan.

#### **B - WAITING PERIOD**

**Priests, Religious and Seminarians:** An employee's Eligibility Date is the first day of service.

**Lay Employees:** An employee's (including Deacons) participation in the Plan is subject to a waiting period of sixty (60) days of full-time employment, from the date such full-time employment begins.

An employee's Eligibility Date is the next day following completion of the waiting period.

Part-time employees working a minimum of 20 hours per week (but no less than 1000 hours per year) immediately preceding the date that they become a full-time employee may be given partial credit towards satisfaction of the waiting period.

#### **C - PLAN ENROLLMENT**

An Eligible Lay Employee must participate in the Plan and is required to complete, sign and return the enrollment form to the Employer.

#### **D - RE-HIRE**

If an employee who was previously covered by this Plan is re-hired within six (6) months after termination of employment, coverage will become effective on the date of re-employment and the waiting period will be waived. However, the Pre-Existing Conditions Limitation and Creditable Coverage provisions will apply for Covered Persons age nineteen (19) and over.

If an employee who was previously covered by this Plan is re-hired more than six (6) months after termination of employment, the employee will be considered a new employee and will be subject to all provisions of this Plan.

#### **E - RETURN TO WORK – USERRA**

Employees who are covered under the Uniformed Services Employment and Reemployment Rights Act (USERRA) will be eligible for coverage on the date they return to work, provided the employee returns to work with the Employer within the specified time period in the Uniformed Services Employment and Reemployment Rights Act (USERRA). Coverage for a reservist will be on the same basis it is for active employees and dependents. Eligibility waiting periods and the Pre-Existing Condition Limitation will be imposed only to the extent they were applicable prior to the period of uniformed services.

## ELIGIBILITY & ENROLLMENT

### DEPENDENTS

#### A - ELIGIBLE DEPENDENTS

An Eligible Dependent will be a Covered Employee's legally married spouse and each Dependent Child and Qualifying Child until the date in which the child attains age twenty-six (26), provided such child does not have coverage available through another employer-sponsored group health plan (other than one available through his or her parent's employer). The term "married" means only a legal union between one man and one woman as husband and wife, and the term "spouse" refers only to a person of the opposite sex who is a husband or wife.

The term "Dependent Child" shall mean a Covered Employee's natural born son, daughter, stepson, stepdaughter, or legally adopted child (from the date of placement with the employee for the purpose of legal adoption).

The term "Qualifying Child" shall mean any child for which the Covered Employee has obtained legal guardianship (coverage will remain in effect until such child no longer meets the age requirements of an Eligible Dependent under the terms of the Plan, regardless of whether or not such child has attained age eighteen (18) (or any other applicable age of emancipation of minors) and therefore, the Covered Employee is no longer considered such child's legal guardian); provided however that the child is unmarried and primarily dependent upon the Covered Employee for support. If the child is not a relative (as defined in Code Section 152(d) for qualifying relatives) of the Covered Employee, then such child, in addition to all other requirements, must reside with the covered Employee for more than ½ of the Calendar Year.

A child for whom the Covered Employee is required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO) shall also be considered an Eligible Dependent. Procedures for determining a QMCSO may be obtained from the Plan Administrator at no cost.

The Plan Administrator shall have the right to require documentation necessary, in its sole discretion, to establish an individual's status as an Eligible Dependent.

No individual may be covered under this Plan as both an employee and a dependent. Also, no individual will be considered an Eligible Dependent of more than one employee.

**Mentally or Physically Handicapped Child:** If a Dependent Child or Qualifying Child age twenty-six (26) or older is unable to be self-supporting by reason of mental or physical handicap and is incapacitated, such child will be considered an Eligible Dependent for purposes of this Plan; provided the child suffered such incapacity prior to the date in which the child attained age twenty-six (26). The child must be unmarried, primarily dependent upon the employee for support and have the same principal residence of the employee.

#### B - PLAN ENROLLMENT

An Eligible Dependent is able to participate in the Plan when the Covered Employee completes, signs and returns an enrollment form indicating dependent coverage to the Employer. The employee must enroll the dependent(s) within thirty-one (31) days of whichever of the following occurs first:

1. The employee's Eligibility Date if the employee has any Eligible Dependents at that time; or
2. The date the employee acquires an Eligible Dependent.

Children covered by Qualified Medical Child Support Orders (QMCSO) will be enrolled in this Plan if the employee would otherwise be eligible for coverage. The Plan must enroll the child(ren) covered by the notice without any enrollment restrictions (i.e. they will not be considered Late Enrollees).

Newborn children and adopted children will be covered on the date of birth or adoption (or placement for adoption) if enrolled within thirty-one (31) days of the birth, adoption or placement for adoption.

Failure to enroll for dependent coverage within this time limit will be deemed waiver of participation and future coverage for dependents under the Plan will be subject to the Late Enrollee or Special Enrollee provisions.

**Special Enrollee:** If an employee is declining enrollment for dependent coverage because of other health coverage under a Qualified Health Plan, the employee may in the future be able to enroll for dependent coverage, provided the request for enrollment is received within thirty-one (31) days after coverage under the Qualified Health Plan terminates due to one or more of the following:

1. Loss of eligibility, which includes, but is not limited to:
  - (a) Legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be considered an Eligible Dependent under the plan), death of an employee, termination of employment, reduction in the number of hours of employment;
  - (b) Coverage is offered through an HMO or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual);
  - (c) Coverage is offered through an HMO or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
  - (d) When a plan no longer offers any benefits to a class of similarly situated individuals, i.e. terminated coverage for part-time employees, etc.;
  - (e) When a Covered Person incurs a claim that would meet or exceed a lifetime limit on all benefits (this right continues until at least 31 days after the earliest date that a claim is denied due to the operation of the lifetime limit);
  - (f) The spouse's employer offers an open enrollment period at which time the spouse declines coverage under their employer-sponsored plan (termination of coverage must occur during an open enrollment period).
2. Termination of employer contributions toward the cost of coverage; or
3. COBRA continuation coverage is exhausted.

If an employee has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may be able to enroll for dependent coverage, provided the employee requests enrollment within thirty-one (31) days after the marriage, birth, adoption or placement for adoption of a new dependent child.

A written waiver of coverage stating the existence of coverage under another Qualified Health Plan must have been completed by the employee in order for the dependent to be considered a Special Enrollee at a later date.

The Pre-Existing Condition Limitation and Creditable Coverage provisions will apply for Covered Persons age nineteen (19) and over.

#### **Special enrollment due to coverage under Medicaid or under a State Children's Health Insurance Program (CHIP)**

If an employee or eligible dependent did not enroll in the Plan when initially eligible, but was otherwise eligible to enroll, they will be permitted to later enroll in the Plan under one of the following circumstances:

1. The employee or eligible dependent was covered under Medicaid or CHIP at the time of initial enrollment and such coverage subsequently terminates; or
2. The employee or eligible dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP subsequent to the time they were initially eligible.

The employee or dependent must request enrollment in the Plan within sixty (60) days after coverage under Medicaid or CHIP terminates or within sixty (60) days after their eligibility for a premium assistance subsidy under Medicaid or CHIP is determined, whichever is applicable.

**Annual Enrollment:** A Late Enrollee will be eligible to enroll for coverage under this Plan in the future, subject to the Pre-Existing Condition Limitation and Creditable Coverage provisions. See the **Effective Date of Coverage** section.

There will be an annual enrollment period to be determined by the Employer, at which time an employee may elect dependent coverage for Late Enrollees under the Plan to be effective on January 1<sup>st</sup>. The waiting period will be waived; however, the Pre-Existing Condition Limitation and Creditable Coverage provisions will apply for Covered Persons age nineteen (19) and over.

Also during this annual enrollment period, Covered Employees and their covered dependents will be able to make a change in coverage under this Plan. Plan choices made during the annual enrollment period will become effective January 1<sup>st</sup> and remain in effect until the next January 1<sup>st</sup>, unless there is a special enrollment period. In addition, should a Covered Employee experience a Qualifying Event that would allow them to drop their dependent (s), a request in writing must be submitted to HR within thirty (30) days of the Qualifying Event in order to make the plan change. If the request is not submitted within thirty (30) days, then the current coverage will remain in place until the next Annual Enrollment Period. A Covered Employee who fails to make an election during annual enrollment will automatically retain their present coverage.

## **EFFECTIVE DATE OF COVERAGE**

### **A – EMPLOYEES**

Coverage for an Eligible Employee will be effective on the employee's Eligibility Date.

### **B – DEPENDENTS**

When a Covered Employee enrolls an Eligible Dependent in the Plan, the dependent's coverage will be effective on whichever of the following occurs later:

1. The employee's effective date of coverage;
2. The day following the date the dependent's coverage terminated due to loss of eligibility under a Qualified Health Plan, or termination of employer contributions toward the cost of coverage through a Qualified Health Plan, provided enrollment is made within thirty-one (31) days in the case of a Special Enrollee;
3. The date of marriage, provided the dependent is enrolled within thirty-one (31) days following the marriage;
4. The date of birth or adoption (or placement for adoption) if enrolled within thirty-one (31) days of the birth, adoption or placement for adoption;
5. The day following the date in which COBRA coverage is exhausted if the dependent had elected COBRA coverage under a Qualified Health Plan in the case of a Special Enrollee;
6. The date the Late Enrollee enrolls or January 1<sup>st</sup> following the annual enrollment period for a Late Enrollee; or
7. The day following the date the employee or dependent's coverage under Medicaid or CHIP terminated, or following the date their eligibility for a premium assistance subsidy under Medicaid or CHIP is determined, whichever is applicable, provided enrollment is received within sixty (60) days of whichever is applicable.

## ELIGIBLE MEDICAL EXPENSES

Eligible expenses shall be the charges actually made to the Covered Person and, unless otherwise shown, will be considered eligible only if the expenses are:

1. Due to Illness or Injury;
2. Ordered or performed by a Physician;
3. Medically Necessary; and
4. Usual and Customary Charges.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted. All eligible expenses incurred at a Preferred Provider will be reimbursed to the provider.

1. **ALLERGY SERVICES:** Allergy testing, treatment, serum and injections will be payable as shown in the **Schedule of Medical Benefits**.
2. **AMBULANCE SERVICE:** Local Medically Necessary professional ground or air ambulance service will be payable as shown in the **Schedule of Medical Benefits** to transport the patient: (a) to the nearest Hospital or Skilled Nursing Facility equipped to treat the specific Illness or Injury, unless the Plan Administrator finds a longer trip was Medically Necessary; or (b) when Medically Necessary.
3. **AMBULATORY SURGICAL FACILITY:** Services and supplies provided by an Ambulatory Surgical Facility.
4. **ANESTHETICS:** Anesthetics and their professional administration.
5. **ATTENTION DEFICIT DISORDER:** Diagnosis, testing and treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), and autism.
6. **BLOOD AND BLOOD DERIVATIVES:** Blood, blood plasma, or blood components not donated or replaced.
7. **CARDIAC REHABILITATION:** As deemed Medically Necessary provided services are rendered: (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within twelve (12) weeks after other treatment for the medical condition ends; and (d) in a medical care facility.
8. **CHIROPRACTIC CARE:** Chiropractic treatment when related to the spine, muscles or joints, including x-rays will be payable as shown in the **Schedule of Medical Benefits**.
9. **CIRCUMCISION:** Services and supplies related to circumcision. Circumcision performed while Hospital confined following birth will be paid the same as Routine Newborn Care.
10. **CLINICAL TRIAL PROGRAMS:** Clinical trial programs for the treatment of children's cancer with respect to those dependent children who: (a) are covered under the Plan; (b) have been diagnosed with cancer prior to their nineteenth (19<sup>th</sup>) birthday; (c) are enrolled in an approved clinical trial program for treatment of children's cancer; and (d) are not otherwise eligible for benefits, payments, or reimbursements from any other third party payors or other similar sources.
11. **COSMETIC SURGERY:** Charges for Cosmetic Surgery or reconstructive surgery will be considered eligible only under the following circumstances: (a) for the correction of congenital defects for a dependent child; and (b) any other Medically Necessary surgery related to an Illness or Injury.
12. **DENTAL CARE:** Dental services and x-rays rendered by Dentist or dental surgeon for:
  - (a) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
  - (b) Emergency repair due to Injury to sound natural teeth;
  - (c) Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth;
  - (d) Excision of benign bony growths of the jaw and hard palate;
  - (e) External incision and drainage of cellulitis;

- (f) Incision of sensory sinuses, salivary glands or ducts;
- (g) Removal of impacted teeth.

General anesthesia and Hospital expenses for a person who is: (a) seven (7) years of age or younger or is developmentally disabled; (b) an individual for which a successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition of the Covered Person; or (c) an individual who has sustained extensive facial or dental trauma.

13. **DIABETIC SUPPLIES:** Diabetic supplies for the treatment of diabetes that are not covered under the Prescription Drug Card program.

The following diabetic education and self-management programs: (a) all Physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes; and (b) diabetes outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes who adhere to the prognosis and treatment regimen prescribed by a Physician.

14. **DIAGNOSTIC TESTING, X-RAY AND LABORATORY SERVICES:** Diagnostic testing, x-ray, and laboratory services, including services of a professional radiologist or pathologist. Outpatient services will be payable as shown in the **Schedule of Medical Benefits**. Dental x-rays are not eligible expenses, except as specified under **Dental Care**.

The use of the Lab Card program offered by Quest Diagnostics is strictly voluntary. If a Covered Person uses the services of the Lab Card Program, benefits will be payable as shown in the **Schedule of Benefits**. When a Physician orders laboratory work, the Covered Person should present the Lab Card or medical ID card with the Lab Card logo on it and verbally request to use the Lab Card Program. The Physician will then collect the specimen and send to Quest Diagnostics. Any Physician can collect specimens and call Quest Diagnostics Lab Card Client Services at (800) 646-7788 for courier pick-up and supplies. In the event the Physician does not participate with the Lab Card Program, simply take the test orders to an approved Lab Card collection site for the draw. Collection site locations can be found by calling Lab Card Client Services or by going to the website at [www.labcard.com](http://www.labcard.com).

The Lab Card Program covers routine outpatient testing. The Lab Card does **NOT** cover: (a) testing ordered during hospitalization; (b) lab work needed on an emergency or (STAT) basis; (c) testing done at another laboratory; or (d) time sensitive esoteric testing such as fertility testing, bone marrow studies and spinal fluid tests.

15. **DURABLE MEDICAL EQUIPMENT:** The rental of oxygen equipment, wheelchairs, walkers, special Hospital beds, iron lungs, and other Durable Medical Equipment which are prescribed by a Physician for the treatment of an Illness or Injury will be payable as shown in the **Schedule of Medical Benefits**.

When the extended use of any eligible rental equipment is deemed necessary for the treatment of the patient, purchase of the equipment may be permitted. The total cost of rental and purchase will never exceed the purchase price of the equipment.

16. **EMERGENCY ROOM SERVICES:** Treatment in a Hospital emergency room, including professional services will be payable as shown in the **Schedule of Medical Benefits**.

17. **EXTENDED CARE FACILITY:** Extended convalescent care provided in an Extended Care Facility will be payable as shown in the **Schedule of Medical Benefits**, provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Rehabilitation Facility confinement; and (c) is not for Custodial Care.

See the Rehabilitation Facility benefit for services and supplies provided for confinements in a Rehabilitation Facility.

18. **HOME HEALTH CARE:** Services provided by a Home Health Care Agency to a Covered Person in the home will be payable as shown in the **Schedule of Medical Benefits**. The following are considered eligible home health care services: (a) home nursing care; (b) services of a home health aide or licensed practical nurse (L.P.N.), under the supervision of a registered nurse (R. N.); (c) physical, occupational or speech therapy if provided by the Home Health Care Agency; (d) medical supplies, drugs and medications prescribed by a Physician; (e) laboratory services; and (f) nutritional counseling by a licensed dietician.

For the purpose of determining the benefits for home health care available to a Covered Person, each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and each four (4) hours of home health aide services shall be considered as one home health care visit.

In no event will the services of a Close Relative, social worker, transportation services, housekeeping services, and meals, etc. be considered an eligible expense.

19. **HOSPICE CARE:** Hospice care on either an Inpatient or outpatient basis for a terminally ill person rendered under a Hospice treatment plan will be payable as shown in the **Schedule of Medical Benefits**. The Hospice treatment plan must certify that the person is terminally ill with a life expectancy of six (6) months or less.

Covered services include: (a) room and board charges by the Hospice; (b) other Medically Necessary services and supplies; (c) nursing care by or under the supervision of a registered nurse (R.N.); (d) home health care services furnished in the patient's home by a Home Health Care Agency for the following: (i) health aide services consisting primarily of caring for the patient (excluding housekeeping, meals, etc.); and (ii) physical and speech therapy; (e) counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family; (f) bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family. (The bereavement services must be furnished within 12 months after the patient's death.)

The term "Patient's Immediate Family" as used herein means the patient's spouse, parents, and/or dependent children who are covered under the Plan.

20. **HOSPITAL SERVICES:**

Inpatient

Hospital room and board, including all regular daily services will be payable as shown in the **Schedule of Medical Benefits**. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.

Care provided in an Intensive Care Unit will be payable as shown in the **Schedule of Medical Benefits**.

Miscellaneous services and supplies, including any additional Medically Necessary nursing services furnished while being treated on an Inpatient basis.

Outpatient

Services and supplies furnished while being treated on an outpatient basis will be payable as shown in the **Schedule of Medical Benefits**.

21. **MATERNITY:** Expenses incurred by an employee or a dependent spouse for:

- (a) Pregnancy;
- (b) Services provided by a Birthing Center;
- (c) One amniocentesis test per pregnancy;
- (d) Up to two (2) ultrasounds per pregnancy (more than 2 only when it is determined to be Medically Necessary).

Hospital stays in connection with childbirth for either the mother or newborn may not be less than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Covered Person or provider is not required to pre-certify the maternity admission, unless the stay extends past the applicable forty-eight (48) or ninety-six (96) hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth. **If a newborn remains hospitalized beyond the time frames specified above, the confinement must be pre-certified or a penalty may be applied.**

22. **MEDICAL AND SURGICAL SUPPLIES:** Casts, splints, trusses, braces, crutches, dressings and other Medically Necessary supplies ordered by a Physician.
23. **MENTAL DISORDERS:** Inpatient and outpatient treatment of Mental Disorders, including emergency care, transition day treatment, partial hospitalization, and transitional rehabilitation will be payable as shown in the **Schedule of Medical Benefits**.
24. **OCCUPATIONAL THERAPY:** Occupational therapy rendered by an occupational therapist under the recommendation of a Physician and necessary due to Illness or Surgery, or to improve a body function. Outpatient occupational therapy will be payable as shown in the **Schedule of Medical Benefits**.
25. **OUTPATIENT PRE-ADMISSION TESTING:** Outpatient pre-admission testing performed within seven (7) days of a scheduled Inpatient hospitalization or Surgery.
26. **OXYGEN:** Oxygen and rental of equipment for its administration.
27. **PHENYLKETONURIA:** Special dietary treatment for phenylketonuria (PKU) when recommended by a Physician.
28. **PHYSICAL THERAPY:** Physical therapy rendered by a physical therapist under the recommendation of a Physician. Outpatient physical therapy will be payable as shown in the **Schedule of Medical Benefits**.
29. **PHYSICIAN'S SERVICES:** Services of a Physician for medical care or Surgery.

Services performed in a Physician's office on the same day for the same or related diagnosis, regardless if a Physician is seen or not, will be payable as shown in the **Schedule of Medical Benefits**. Services include, but are not limited to: examinations, x-ray and laboratory tests (including the reading or processing of the tests), supplies, injections, cast application and minor Surgery. If more than one Physician is seen in the same clinic on the same day, only one Co-pay will apply.

Any diagnostic x-ray and laboratory services which are performed or read at a another facility outside the Physician's office will be considered a separate benefit and will be payable subject to the Deductible and Co-insurance.

30. **PODIATRY:** Treatment for the following foot conditions: (a) bunions, when an open cutting operation is performed; (b) non-routine treatment of corns or calluses; (c) toenails when at least part of the nail root is removed; or (d) any Medically Necessary surgical procedure required for a foot condition. Routine foot care needed due to a diabetic condition will be considered eligible.
31. **PRIVATE DUTY NURSING:** Service of a registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.) for private duty nursing as follows:
  - (a) Inpatient private duty nursing is covered only when care is Medically Necessary and not for Custodial Care, and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
  - (b) Outpatient private duty nursing is covered only when Medically Necessary and will be payable under the Home Health Care benefit.
32. **PROSTHETICS:** Artificial limbs, eyes, or other prosthetic devices when necessary due to an Illness or Injury, but not the replacement thereof, unless replacement is necessitated by normal growth, development or physical changes. The Plan will consider cost of repairs due to wear and tear of prosthesis if it is more cost-efficient than replacement.
33. **RADIATION AND X-RAY THERAPY:** Radium, radioactive isotope therapy, chemotherapy and x-ray therapy treatment.
34. **RECONSTRUCTIVE BREAST SURGERY:** Charges for reconstructive breast surgery following a mastectomy will be eligible as follows: (a) reconstruction of the breast on which the mastectomy has been performed; (b) surgery and reconstruction of the other breast to produce symmetrical appearance; and (c) coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas. The manner in which breast reconstruction is performed will be determined in consultation with the attending Physician and the patient.

35. **REHABILITATION FACILITY:** Inpatient care provided in a Rehabilitation Facility will be payable as shown in the **Schedule of Medical Benefits**, provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Extended Care Facility confinement; and (c) is not for Custodial Care.

See the Extended Care Facility benefit for services and supplies provided for confinements in an Extended Care Facility.

36. **ROUTINE CANCER SCREENING (PPO PROVIDERS ONLY):** The following routine cancer screening procedures (as outlined by the American Cancer Society) will be payable as shown in the **Schedule of Medical Benefits**:

#### Colon and Rectal Exams

Beginning at age fifty (50), both men and women are eligible for these five (5) testing schedules:

- Yearly fecal occult blood test (FOBT)
- Flexible sigmoidoscopy every five (5) years
- Yearly fecal occult blood test plus flexible sigmoidoscopy every five (5) years
- Double-contrast barium enema every five (5) years
- Colonoscopy every five (5) years

#### Cervical Cancer:

- Beginning at age twenty-one (21), annual screenings are eligible every year with the regular Pap test or every two (2) years with the new liquid-based Pap test.
- Beginning at age thirty (30), women who have had three normal Pap test results in a row may get screened every two (2) to three years with either the convention (regular) or liquid-based Pap test. Women who have certain risk factors such as diethylstilbestrol (DES) exposure before birth, HIV infection, or a weakened immune system due to organ transplant, chemotherapy, or chronic steroid use may continue to be screened annually.
- Women over thirty (30) may also be screened every three (3) years (but not more frequently) with either the convention or liquid-based Pap test, *plus* the HPV DNA test.
- Women seventy (70) years of age or older who have had three (3) or more normal Pap tests in a row and no abnormal Pap test results in the last ten (10) years may choose to stop having cervical cancer screening. Women with a history of cervical cancer, DES exposure before birth, HIV infection or a weakened immune system may continue to have screening as long as they are in good health.
- Women who have had a total hysterectomy (removal of the uterus and cervix) may choose to stop having cervical cancer screening, unless the surgery was performed as a treatment for cervical cancer or precancer. Women who have had a hysterectomy without the removal of the cervix may continue to follow the guidelines above.

#### Prostate Cancer

- Beginning at age fifty (50), both the prostate-specific antigen (PSA) blood test and digital rectal examination (DRE) may be offered annually to men who have at least a ten (10) year life expectancy.
- Men at high risk (African-American men and men with a strong family history of one or first degree relatives (father, brothers) diagnosed at an early age) may begin testing at age forty-five (45).
- Men at even higher risk, due to multiple first-degree relatives affected at an early age, may begin testing at age forty (40).

#### Endometrial (Uterine) Cancer

- For women with or at high risk for hereditary nonpolyposis colon cancer (HNPCC), annual screening may be eligible for endometrial cancer with endometrial biopsy beginning at age thirty-five (35).

#### Mammograms

Routine mammograms may be payable as follows: (a) yearly mammograms starting at age forty (40) and continuing for as long as a woman is in good health; and (b) clinical breast exams (CBE) may be part of a periodic health exam every three (3) years for women in their 20s and 30s and every year for women forty (40) and over.

If a diagnosis is indicated after any routine screening procedure, the screening will still be payable under the routine cancer screening benefit, however, all charges related to the diagnosis (except the initial screening) will be payable as any other illness.

37. **ROUTINE CARE (PPO PROVIDERS ONLY):** Routine care age seventeen (17) and over, including, but not limited to, the items listed below and the office visit, lab tests, x-rays, routine testing, vaccinations or inoculations, vision and hearing exams, and bone mass measurement for the prevention, diagnosis and treatment of osteoporosis will be payable as shown in the **Schedule of Medical Benefits**. If a diagnosis is indicated after a routine exam, the exam will still be payable under the routine care benefit, however, all charges related to the diagnosis (except the initial exam) will be payable as any other illness.

Any routine cancer screening procedures which fall outside the parameters as listed under number (37) - Routine Cancer Screenings will be payable under this Routine Care benefit.

38. **ROUTINE NEWBORN CARE:** Routine newborn care, including Hospital nursery expenses and routine pediatric care while confined following birth will be payable as shown in the **Schedule of Medical Benefits**.

If the newborn is ill, suffers an Injury, or requires care other than routine care, benefits will be provided on the same basis as any other eligible expense.

39. **SECOND SURGICAL OPINIONS:** Voluntary second surgical opinions for elective, non-emergency Surgery when recommended for a Covered Person.

Benefits for the second opinion will be payable only if the opinion is given by a specialist who: (a) is certified in the field related to the proposed Surgery; and (b) is not affiliated in any way with the Physician recommending the Surgery.

40. **SMOKING CESSATION:** Smoking cessation programs, smoking deterrents (prescription and over-the-counter) will be payable as shown in the **Schedule of Medical Benefits**.

41. **SPEECH THERAPY:** Restorative or rehabilitative speech therapy under the recommendation of a Physician and necessary because of loss or impairment due to an Illness or Surgery, or therapy to correct a congenital defect other than a learning disorder. Speech therapy for developmental delay will not be considered eligible. Outpatient speech therapy will be payable as shown in the **Schedule of Medical Benefits**.

42. **TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ):** Surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ), mandible or maxillofacial disorders.

43. **TRANSPLANTS:** Services and supplies in connection with Medically Necessary non-Experimental transplant procedures, subject to the following conditions:

**Case Management is REQUIRED for transplant related claims when using the Aetna Network.**

- (a) A concurring opinion must be obtained prior to undergoing any transplant procedure. This mandatory opinion must concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this concurring opinion must be qualified to render such a service either through experience, specialist training, education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual Surgery.
- (b) If the donor is covered under this Plan and the recipient is not, then the Plan will cover donor organ or tissue charges for (i) evaluating the organ or tissue; (ii) removing the organ or tissue from the donor. No transportation charges will be considered. This Plan will always pay secondary to any other coverage. If the donor is not covered under this Plan, reference provision (d). If the recipient is covered under this Plan, eligible medical expenses incurred by the recipient will be considered eligible.
- (c) If both the donor and the recipient are covered under this Plan, eligible medical expenses incurred by each person will be treated separately for each person.
- (d) The Usual and Customary fee of securing an organ from the designated live donor, a cadaver or tissue bank, including the surgeon's fees, anesthesiology, radiology and pathology fees for the removal of the organ, and a Hospital's charge for storage or transportation of the organ will be considered eligible.

Transplant coverage is limited to those transplants that are medically recognized and are non-Experimental/Investigational in nature. Transplants contrary to Church Doctrine are not considered eligible expenses.

## **AETNA INSTITUTE OF EXCELLENCE (IOE)**

This is a facility that is contracted with Aetna to furnish particular services and supplies to a Covered Person in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

**Aetna Transplant Expenses.** Once it has been determined that a Covered Person may require an organ transplant, the Covered Person, or the Physician should call Meritain Health<sup>sm</sup> Medical Management to discuss coordination of the transplant care. **Case Management is required to be eligible for benefits through the Aetna Network.** Aetna will coordinate all transplant services. In addition, the Covered Person must follow any Pre-certification requirements. Organ means solid organ; stem cell; bone marrow; and tissue.

Benefits may vary if an Institute of Excellence - (IOE) facility or non-IOE is used. In addition, the travel and lodging expenses below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure required. A transplant will be covered at the PPO level only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any treatment or service related to transplants that are provided by a facility that is not specified as an IOE network facility, even if the facility is considered as a preferred facility for other types of services, will be covered at the Non-PPO level. Please read each section carefully.

Covered transplant expenses include the following:

- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are a biological parent, sibling or child.
- Inpatient and outpatient expenses directly related to a transplant.
- Charges made by a Physician or transplant team.
- Charges made by a Hospital, outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the IOE facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant expenses are typically incurred during the four (4) phases of transplant care described below. Expenses incurred for one transplant during these four (4) phases of care will be considered one Transplant Occurrence.

A Transplant Occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date the Covered Person is discharged from the Hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four (4) phases of one Transplant Occurrence and a summary of covered transplant expenses during each phase are:

- (a) Pre-transplant Evaluation/Screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.
- (b) Pre-transplant/Candidacy Screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members.
- (c) Transplant Event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to the recipient and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during the Inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during the Inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement.

- (d) Follow-up Care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within one hundred eighty (180) days from the date of the transplant event.

For the purposes of this section, the following will be considered to be one Transplant Occurrence:

- Heart
- Lung
- Heart/ Lung
- Simultaneous Pancreas Kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone Marrow/Stem Cell transplant
- Multiple organs replaced during one transplant surgery
- Tandem transplants (Stem Cell)
- Sequential transplants
- Re-transplant of same organ type within 180 days of the first transplant
- Any other single organ transplant, unless otherwise excluded under the Plan

The following will be considered to be more than one Transplant Occurrence:

- Autologous Blood/Bone Marrow transplant followed by Allogenic Blood/Bone Marrow transplant (when not part of a tandem transplant)
- Allogenic Blood/Bone Marrow transplant followed by an Autologous Blood/Bone Marrow transplant (when not part of a tandem transplant)
- Re-transplant after 180 days of the first transplant
- Pancreas transplant following a kidney transplant
- A transplant necessitated by an additional organ failure during the original transplant surgery/process.
- More than one transplant when not performed as part of a planned tandem or sequential transplant (e.g., a liver transplant with subsequent heart transplant).

**Limitations.** The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient Transplant Occurrence.
- Services and supplies furnished to a donor when recipient is not a Covered Person.
- Home infusion therapy after the Transplant Occurrence.
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness.
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness.
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Aetna.

**Travel & Lodging Expenses** To be eligible for travel and lodging reimbursement, the member or provider must pre authorize evaluation and treatment and utilize a IOE transplant facility.

Distance Requirement The IOE facility must be more than 100 miles from the patient's residence.

Travel Allowances Travel is reimbursed between the patient's home and the facility for round trip (air, train or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking and toll cost are reimbursed. Mileage reimbursement is \$0.14/mile.

Lodging/Meal Allowances Reimbursement of expenses incurred by patient and companion for hotel lodging and meals away from home is reimbursed at a daily rate of \$200.

Companions Adult – 1 companion is permitted. Child – 1 parent or guardian is permitted.

44. **URGENT CARE FACILITY:** Services and supplies provided by an Urgent Care Facility will be payable as shown in the **Schedule of Medical Benefits**.
45. **VISION MATERIALS:** Lenses, frames, contacts and any fitting and related office visit will be payable as shown in the **Schedule of Medical Benefits**.
46. **WELL CHILD CARE (PPO PROVIDERS ONLY):** Well child care up through age sixteen (16), including, but not limited to, vaccinations and immunizations, routine office visits, developmental assessments, vision and hearing exams, and related laboratory tests and x-rays will be payable as shown in the **Schedule of Medical Benefits**.
47. **WIG DUE TO CHEMOTHERAPY:** Purchase of a scalp hair prosthesis (wig) when necessitated by hair loss due to radiation or chemotherapy will be payable as shown in the **Schedule of Medical Benefits**.

## **MEDICAL EXPENSE AUDIT BONUS**

The Plan offers an incentive to all Covered Persons to encourage examination and self-auditing of eligible medical bills to ensure the amounts billed by any provider accurately reflect the services and supplies received by the Covered Person. The Covered Person is asked to review all medical charges and verify that each itemized service has been received and that the bill does not represent either an overcharge or a charge for services never received. This self-auditing procedure is strictly voluntary; however, it is to the advantage of the Plan as well as the Covered Person to avoid unnecessary payment of health care costs.

In the event a self-audit results in elimination or reduction of benefits paid, 25% of the amount saved will be reimbursed directly to the employee (subject to a \$10 minimum payment and a \$500 maximum payment per Calendar Year), provided the savings are accurately documented, and satisfactory evidence is submitted to the Contract Administrator (e.g. a copy of the incorrect bill and a copy of the corrected billing).

This self-audit credit is in addition to the payment of all other applicable plan benefits for legitimate medical expenses.

This credit will not be payable for expenses in excess of the Usual and Customary Charges or expenses which are not covered under the Plan, regardless of whether benefits paid are reduced.

## **ALTERNATIVE BENEFITS**

In addition to the benefits specified, the Plan may elect to offer benefits for services furnished by any provider pursuant to a Plan-approved alternative treatment plan, in which case those charges incurred for services provided to a Covered Person under an alternate treatment plan to its end, will be more cost effective than those charges to be incurred for services to be provided under the current treatment plan to its end.

The Plan shall provide such alternative benefits at its sole discretion and only when and for so long as it determines that alternative care services are Medically Necessary and cost effective. If the Plan elects to provide alternative benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the Plan Administrator's rights to administer this Plan thereafter in strict accordance with its express terms.

## **PRE-EXISTING CONDITION LIMITATION (Does not apply to Covered Persons under age 19)**

Expenses incurred in connection with a Pre-Existing Condition will not be considered eligible. A Pre-Existing Condition is defined as an Illness or Injury (whether physical or mental), regardless of cause, for which medical advice, diagnosis, care, or treatment was recommended or received during the **three (3)** consecutive month period prior to the individual's Enrollment Date of coverage under this Plan.

Pre-Existing Conditions will be covered after the end of:

1. **Six (6)** consecutive months after the employee's Enrollment Date; or
2. **Twelve (12)** consecutive months after the dependents's Enrollment Date.

The Pre-Existing Condition Limitation does not apply to:

1. Covered Persons under age nineteen (19).
2. Maternity benefits.
3. Genetic Information provided there has been no diagnosis of a condition related to the Genetic Information.
4. Prescription drugs purchased through the Prescription Drug Card program.
5. An employee and/or dependent who was covered under a Qualified Health Plan which is replaced by this Plan, unless they have not satisfied the Pre-Existing Condition Limitation of the Qualified Health Plan in effect prior to the effective date of this Plan.

If they have not satisfied the prior plan's Pre-Existing Conditions provision, credit will be given towards this Pre-Existing Condition Limitation for any time which has elapsed while they were covered by a Qualified Health Plan, provided there was not a break in coverage of sixty-three (63) or more days. A certification of Creditable Coverage may be required to accurately determine the Pre-Existing Condition Limitation.

The Plan must establish a procedure for Covered Persons to request and receive a certificate of Creditable Coverage.

Any questions regarding obtaining a Certificate of Creditable Coverage or obtaining credit for additional past periods of coverage, please contact Meritain Health's Service Center at (800) 925-2272, or fax the Certificate(s) of Creditable Coverage from the prior plan(s) to: (952) 593-3779.

If the Plan requests additional information to determine if a pre-existing condition exists or requests a Certificate of Creditable Coverage, and that information is not received as requested, all additional claims related to that condition will receive an Adverse Benefit Determination and will be denied until the necessary information is received. Please refer to the **General Provisions - Right of Review and Appeal** section for further details.

## MEDICAL MANAGEMENT

### Meritain Health<sup>sm</sup> Medical Management

The patient or family member or the patient's representative must call to receive certification of Inpatient Hospital admissions. This call must be made at least twenty-four (24) hours in advance of hospitalization or within seventy-two (72) hours after emergency admission. Failure to comply may reduce benefits.

Meritain Health<sup>sm</sup> Medical Management: 866-405-2021

Meritain Health<sup>sm</sup> Nurseline: 888-229-9301

#### UTILIZATION MANAGEMENT

Utilization Management is a program designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses. The program consists of:

1. Pre-Certification of the Medical Necessity for hospitalization before medical services are provided. Pre-Certification is required for all acute Inpatient stays (including acute Inpatient rehabilitation and subacute care provided in a facility that has nursing staff on-site 24 hours a day, 7 days a week, and a Physician on call 24 hours a day, 7 days a week).
2. Pre-Certification of all chemotherapy and radiation therapy treatment.
3. Concurrent Review for continued length of stay and assistance with discharge planning activities.

**Utilization Management Does Not Guarantee Payment.** All benefits/payments are subject to the Covered Person's eligibility under the Plan. For benefit payment, services rendered must be considered an eligible expense under the Plan and are subject to all other provisions of the Plan.

This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

#### DEFINITIONS

**Concurrent Review:** All Inpatient admissions or confinements that occur in a facility are subject to review by the Utilization Management Staff. The review is based on clinical information received in the utilization management department by the provider or facility.

**Emergency Care:** Medical services and supplies provided after the sudden onset of a medical condition (Injury or Illness) manifesting itself by acute symptoms, including intense pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following: (1) the patient's health would be placed in serious jeopardy; (2) bodily function would be seriously impaired; or (3) there would be serious dysfunction of a bodily organ or part.

**Non-Emergency Care:** Any services which are not considered Emergency Care, or services that are scheduled in advance.

**Pre-Certification:** All Inpatient admissions or confinements that take place in a facility, or any chemotherapy and radiation therapy treatments are subject to review by the Utilization Management Staff. The review is based on clinical information received in the utilization management department from the provider or facility.

#### HERE'S HOW THE PROGRAM WORKS

##### PRE-CERTIFICATION

Before a Covered Person is admitted to a medical facility on a non-emergency basis, or receives any chemotherapy or radiation therapy treatment, the Utilization Management Staff will, based on clinical information from the provider or facility, certify the care according to Meritain Health<sup>sm</sup> Medical Management policy and procedures. A non-emergency stay in a medical facility is one that can be scheduled in advance.

The utilization management program is set in motion by a telephone call from the Covered Person's Provider. To allow for adequate processing of the request, contact the Utilization Management Staff at Meritain Health<sup>SM</sup> Medical Management **at least twenty-four (24) hours** before the Hospital admission or receipt of any chemotherapy or radiation therapy treatment with the following information:

1. Name, identification number and date of birth of the patient;
2. The relationship of the patient to the Covered Employee;
3. Name, identification number, address and telephone number of the Covered Employee;
4. Name of Employer and group number;
5. Name, address, Tax ID #, and telephone number of the admitting Physician;
6. Name, address, Tax ID #, and telephone number of the medical facility with the proposed date of admission and proposed length of stay;
7. Proposed treatment plan; and
8. Admitting diagnosis.

If there is an **emergency** admission to the medical care facility, the patient or the patient's designee, the facility or admitting Physician must contact Meritain Health<sup>SM</sup> Medical Management **within seventy-two (72) hours** after the start of the confinement or on the next business day, whichever is later.

Hospital stays in connection with childbirth for either the mother or newborn may not be less than forty-eight (48) hours following a vaginal delivery, or ninety-six (96) hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother.

The Covered Person or provider is NOT REQUIRED to pre-certify the maternity delivery admission, unless the stay extends past the applicable forty-eight (48) or ninety-six (96) hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth. **If a newborn remains hospitalized beyond the time frames specified above, the confinement must be pre-certified with Meritain Health<sup>SM</sup> Medical Management or a penalty will be applied.**

The Utilization Management Staff, in coordination with the facility and/or provider, will make a determination on the number of days certified based on Meritain Health<sup>SM</sup> Medical Management policy, procedure and guidelines. If the confinement will last longer than the number of days certified, a representative of the Physician or the facility must call Meritain Health<sup>SM</sup> Medical Management before those extra days begin and obtain certification for the additional time. **If the additional days are not requested and certified, room and board expenses will not be payable for any days beyond those certified.**

**If the Covered Person does not receive Pre-Certification as explained in this section, eligible expenses will be reduced by \$500 per occurrence, per individual.**

#### **CONCURRENT REVIEW, DISCHARGE PLANNING**

Discharge planning is part of the utilization management program. The Utilization Management Staff will assist and coordinate the initial implementation of any services the patient will need post hospitalization with the attending Physician and the facility. If the attending Physician feels that it is Medically Necessary for a Covered Person to stay in the medical care facility for a greater length of time than has been pre-certified, the attending Physician or the medical facility must request the additional service or days.

#### **TO FILE A COMPLAINT OR REQUEST AN APPEAL TO A NON-CERTIFICATION**

Verbal appeal requests and information regarding the appeal process should be directed to 1-877-710-0278. From the automated options you must elect the option to speak to an individual to receive information on the appeal process.

## CASE MANAGEMENT

When a catastrophic condition, such as a spinal cord injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps lifetime care. After the patient's condition is diagnosed, the patient might need extensive services or might be able to be moved into another type of care setting, even to the patient's home.

Case management is a program whereby a Case Manager contacts the patient to obtain consent for case management services. The Case Manager monitors the patient and explores, discusses and recommends coordinated and/or alternate types of appropriate medical care. The Case Manager consults with the patient, family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient.

This plan of care may include some or all of the following:

1. Personal support to the patient;
2. Contacting the family to offer assistance and support;
3. Monitoring Hospital or Extended Care Facility care or home health care;
4. Determine alternative care options; and
5. Assisting in obtaining any necessary equipment and services.

Case management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The Case Manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Staff, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

**NOTE: Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.**

**Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.**

## ORGAN TRANSPLANT PROGRAM

Transplant case management is a process for attaining significant cost savings on transplants while ensuring high quality care is provided. It involves patient education regarding the risks and benefits of transplants, and helping the patient to choose an "Institute of Excellence (IOE)" provider. **Case Management is required to be eligible for benefits through the Aetna network.** The Transplant Case Manager coordinates contracting for the transplant, and forwards the patient evaluation to an independent Physician review team for Medical Necessity and Experimental/Investigational determination. The Transplant Case Manager is a patient advocate from diagnosis through the post-operative phase to ensure the best possible care for the patient, while effectively managing the pre- and post-transplant costs. See the **Eligible Medical Expenses** section for further information on eligible transplants.

## ELIGIBLE DENTAL EXPENSES

If a Covered Person incurs expenses for a service on the list of "Eligible Dental Expenses," such charges are covered to the extent that they:

1. Are Usual and Customary;
2. Constitute necessary treatment; and
3. Are incurred while covered under this Plan.

The Plan will pay for such eligible expenses which exceed any applicable Deductible amount as shown in the **Schedule of Dental Benefits**.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted.

### DATE EXPENSES ARE INCURRED

An expense is incurred when the service is performed, except that it is deemed to be incurred:

1. When the impression is taken in the case of dentures, or fixed bridgework;
2. When preparation of the tooth is begun in the case of crown work;
3. When the pulp chamber is opened in the case of root canal therapy.

### ALTERNATIVE TREATMENT

In all cases in which there are optional treatments available which produce a professionally satisfactory result, only the least costly alternative will be considered eligible under this Plan.

### ELIGIBLE DENTAL EXPENSES

The following is a complete list of dental procedures covered under this Dental Expense Benefit, any procedure not listed is excluded.

#### CLASS "A" EXPENSES (Preventive Services):

1. Routine oral exams, including the cleaning and scaling of teeth. Limit of two (2) exams per Covered Person each Calendar Year.
2. One bitewing x-ray series (set of 4) every twelve (12) months.
3. One full mouth x-ray (including bitewings) every thirty-six (36) months.
4. Two (2) fluoride treatments for dependent children under age nineteen (19) each Calendar Year.
5. Space maintainers for dependent children under age sixteen (16) to replace primary teeth.
6. Emergency palliative treatment for pain.
7. Sealants on the occlusal surface of a permanent posterior tooth for dependent children under age sixteen (16), once per tooth in any thirty-six (36) months.
8. Laboratory tests necessary for the diagnosis or treatment of a covered dental disorder, including, but not limited to, bacteriologic cultures and pulp vitality tests.
9. Diagnostic casts for Covered Persons – once per two (2) year period.

**CLASS "B" EXPENSES:**

1. Dental x-rays not included in Class "A" Expenses.
2. Oral surgery, except that which is covered under any medical plan.
3. Periodontics (gum treatments).
4. Endodontics (root canals).
5. Extractions. This service includes local anesthesia and routine post-operative care.
6. Recementing bridges, crowns or inlays.
7. Fillings, other than gold.
8. General or local anesthetics, upon demonstration of Medical Necessity.
9. Antibiotic drugs.
10. Porcelain and stainless steel crowns used in the replacement of deciduous (primary teeth).
11. Repair or recementing of inlays, inlays, bridgework, crowns or dentures. Relining or rebasing of dentures more than one year after installation of either the initial or the replacement denture. Limited to one relining or rebasement in any twenty-four (24) consecutive month period.
12. Injections of antibiotic drugs and/or application of desensitizing medication.

**CLASS "C" EXPENSES:**

1. Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.
2. Installation of crowns.
3. Installing precision attachments for removable dentures.
4. Installing partial, full or removable dentures to replace one or more natural teeth that were extracted while the person was covered for this benefit. This service also includes all adjustments made during six (6) months following the installation.
5. Addition of clasp or rest to existing partial removable dentures.
6. Initial installation of fixed bridgework to replace one or more natural teeth.
7. Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this will apply only if the existing denture or bridgework was installed at least five (5) years prior to its replacement and cannot currently be made serviceable.

**CLASS "D" EXPENSES:**

Treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth. These services include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments and retention appliance. Payments for comprehensive full-banded orthodontic treatments are made in installments.

## DENTAL EXCLUSIONS AND LIMITATIONS

In addition to the **General Exclusions and Limitations** section of this Plan, no payment will be eligible under any portion of this Plan for Dental Expenses incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person, or from future benefits, and any such payment does not waive the written exclusions, limitations or other terms of the Plan.

1. **ADMINISTRATIVE COSTS:** Expenses for administrative costs of completing claim forms or reports or for providing dental records will not be considered eligible.
2. **ALTERNATIVE TREATMENT:** Expenses where there are alternate courses of treatment available carrying different fees, the Plan will provide benefits only for the treatment carrying the lesser fee.
3. **AMERICAN DENTAL ASSOCIATION:** Expenses which do not meet the standards of dental practices accepted by the American Dental Association.
4. **COSMETIC:** Expenses for services or supplies partially or wholly cosmetic in nature will not be considered eligible.
5. **CROWNS:** Expenses for crowns that are restorable by other means or for the purpose of periodontal splinting will not be considered eligible.
6. **DEPARTMENT MAINTAINED BY AN EMPLOYER:** Expenses for services received from a Dentist or dental department maintained by an employer, labor union, etc., where the individual is eligible under any group insurance plan will not be considered eligible.
7. **DUPLICATE DEVICES:** Expenses for duplicate prosthetic devices or appliances; expenses for a lost or stolen dental appliance will not be considered eligible.
8. **HOSPITAL EXPENSES:** Expenses for hospital expenses will not be considered eligible.
9. **IMPLANTS:** Expenses for tooth implants will not be considered eligible.
10. **MEDICAL PLAN:** Expenses which are covered or excluded under the medical plan or expenses which are payable under any medical plan will not be considered eligible.
11. **MISSED APPOINTMENTS:** Expenses for completion of claim forms, missed appointments or telephone consultations will not be considered eligible.
12. **NOT LISTED AS ELIGIBLE:** Expenses for procedures or restorations other than those listed in the **Eligible Dental Expenses** section will not be considered eligible.
13. **NOT PERFORMED BY A DENTIST:** Expenses for treatment by other than a Dentist or physician, except charges for treatment performed under the supervision and direction of a Dentist or physician, by any person duly licensed or certified to perform such treatment under applicable professional statutes and regulations will not be considered eligible.
14. **NOT PRESCRIBED BY A DENTIST:** Expenses for services not prescribed as necessary by a physician or Dentist will not be considered eligible.
15. **ORAL HYGIENE:** Expenses for oral hygiene, dietary or plaque control programs, or other educational programs will not be considered eligible.
16. **PERSONALIZATION:** Expenses for personalization of dentures will not be considered eligible.
17. **SPLINTING:** Expenses for crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, restoring the bite (occlusion) or are cosmetic will not be considered eligible.

18. **TAKE HOME ITEMS:** Expenses for mouth guards or take home items will not be considered eligible.
19. **TEMPORARY PROSTHESIS:** Expenses for a temporary full prosthesis or for adjustment or relining of a prosthesis within six (6) months after the prosthesis is initially furnished will not be considered eligible.
20. **TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ):** Expenses incurred for appliances or restorations in connection with Temporomandibular Joint Dysfunction (TMJ) or myofunctional therapy will not be considered eligible. Please see **Eligible Medical Expenses** for covered expenses.
21. **USUAL AND CUSTOMARY CHARGES:** Expenses in excess of the Usual and Customary Charge will not be considered eligible.

## GENERAL EXCLUSIONS AND LIMITATIONS

No payment will be eligible under any portion of this Plan for expenses incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person, or from future benefits, and any such payment does not waive the written exclusions, limitations or other terms of the Plan.

1. **ABORTIONS:** Expenses related to abortions will not be considered eligible.
2. **ACUPUNCTURE:** Expenses for acupuncture will not be considered eligible.
3. **ALCOHOL:** Expenses incurred for services, supplies, care or treatment of an Injury or Illness which occurred as a result of that Covered Person's illegal use of alcohol will not be considered eligible. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for injured Covered Persons other than the person illegally using alcohol. Treatment as specified in the Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
4. **BIOFEEDBACK:** Expenses for biofeedback will not be considered eligible.
5. **BREAST SURGERY:** Expenses for treatment of gynecomastia will not be considered eligible.
6. **CARDIAC REHABILITATION:** Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made, and exercise therapy that no longer requires the supervision of medical professionals.
7. **CHELATION THERAPY:** Expenses for chelation therapy will not be considered eligible, unless due to heavy metal poisoning. Chelation therapy reduces the plaque deposits in the arteries and other parts of the body.
8. **CLOSE RELATIVE:** Expenses for services, care or supplies provided by a Close Relative will not be considered eligible.
9. **COGNITIVE AND KINETIC THERAPY:** Expenses for cognitive therapy and kinetic therapy will not be considered eligible. Cognitive therapy is defined as therapy which embraces mental activities associated with thinking, learning, and memory. Kinetic therapy is defined as therapy related to motion or movement (i.e. the study of motion, acceleration or rate of change). This exclusion will not apply to expenses related to the diagnosis, testing and treatment of ADD, ADHD or autism.
10. **COMPLICATIONS:** Expenses for care, services or treatment required as a result of complications from a treatment not covered under the Plan will not be considered eligible.
11. **CONTRACEPTIVES:** Expenses for contraceptive procedures and devices, including but not limited to, oral contraceptives or patches (unless for purposes other than birth control and determined to be Medically Necessary), and the placement or removal of a contraceptive device will not be considered eligible.
12. **CONTROLLED SUBSTANCE:** Expenses for services, supplies, care or treatment to a Covered Person for Injury or Illness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician will not be considered eligible. Expenses will be covered for injured Covered Persons other than the person using controlled substances. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
13. **CONVENIENCE ITEMS:** Expenses for personal hygiene and convenience items will not be considered eligible.
14. **COSMETIC SURGERY:** Expenses for Cosmetic Surgery will not be considered eligible, except as specified under **Eligible Medical Expenses**.
15. **COUNSELING:** Expenses for religious, marital, family or relationship counseling will not be considered eligible, except as specified under Hospice Care.

16. **COVERAGE UNDER OTHER PLANS:** Expenses for treatment for which the Covered Person is also eligible for benefits under any other group insurance or service plan through any employer (see **Coordination of Benefits** section); or the medical payment or personal Injury sections of automobile, casualty or liability insurance regardless of whether such policy is owned by the Covered Person or some other party (see **Subrogation** section) will not be considered eligible.
17. **CUSTODIAL CARE:** Expenses for Custodial Care will not be considered eligible, except as specified under the Home Health Care and Hospice Care benefits.
18. **DENTAL CARE:** Expenses incurred in connection with dental care, treatment, x-rays, general anesthesia or Hospital expenses will not be considered eligible, except as specified.
19. **DEVELOPMENTAL DELAYS:** Expenses in connection with the treatment of developmental delays, including, but not limited to speech therapy, occupational therapy, physical therapy and any related diagnostic testing will not be considered eligible. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of ADD, ADHD, or autism.
20. **DURABLE MEDICAL EQUIPMENT:** Expenses for repair or maintenance of Durable Medical Equipment will not be considered eligible. Expenses for the rental or purchase of any type of air conditioner, air purifier, or any other device or appliance will not be considered eligible, except as specified under **Eligible Medical Expenses**.
21. **ELASTIC BANDAGES:** Expenses for elastic bandages or stockings will not be considered eligible.
22. **EXERCISE PROGRAMS:** Expenses for exercise programs for treatment of any condition will not be considered eligible, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
23. **EXPERIMENTAL/INVESTIGATIONAL:** Expenses for services or supplies which are not medically recognized or are Experimental/Investigational in nature will not be considered eligible. This exclusion will not apply to clinical trial programs covered under **Eligible Medical Expenses**.  
  
This exclusion will also not apply if the treatment the Covered Person is receiving is the only treatment available and/or is considered standard of care and does not violate church doctrine.
24. **FELONY/ILLEGAL OCCUPATION:** Expenses caused or contributed by a Covered Person committing or attempting an assault, felony or criminal act, participating in an illegal occupation, or actively participating in a violent disorder or riot will not be considered eligible. Actively participating does not include being at the scene of a violent disorder or riot while performing their official duties. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.
25. **FOOT CARE:** Expenses for routine foot care or treatment of weak, unstable or flat feet will not be considered eligible, except foot care needed due to a diabetic condition.
26. **FOOT ORTHOTICS:** Expenses for foot orthotics, orthopedic shoes, arch supports, or for the exam, prescription or fitting thereof will not be considered eligible.
27. **GENETIC TESTING:** Expenses for genetic testing or genetic counseling will not be considered eligible, except amniocentesis testing as specified under **Eligible Medical Expenses**.
28. **GOVERNMENTAL AGENCY:** Expenses for services and supplies which are provided by any governmental agency for which the Covered Person is not liable for payment will not be considered eligible. In the case of a state-sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered Person eligible under TRICARE (the government sponsored program for military dependents).
29. **GROWTH HORMONES:** Expenses for growth hormone drugs or stimulants will not be considered eligible, unless deemed Medically Necessary.

30. **HAIR LOSS:** Expenses for care and treatment of hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, will not be considered eligible, except as specified under **Eligible Medical Expenses**.
31. **HEARING AIDS:** Expenses for hearing aids, including the fitting thereof, will not be considered eligible.
32. **HOME BIRTHS.** Expenses related to giving birth at home will not be considered eligible.
33. **HOMEOPATHIC TREATMENT:** Expenses for naturopathic and homeopathic treatments, services and supplies will not be considered eligible.
34. **HOSPITAL EMPLOYEES:** Expenses for professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service will not be considered eligible.
35. **HUMAN SUBJECT STUDY:** Expenses which are performed subject to the Covered Person's informed consent under a treatment protocol that explains the treatment or procedure as being conducted under a human subject study experiment will not be considered eligible.
36. **HYPNOTHERAPY:** Expenses for hypnotherapy will not be considered eligible.
37. **INFERTILITY:** Expenses for confinement, treatment, testing or service related to infertility (the inability to conceive) or the promotion of conception will not be considered eligible.
38. **MAINTENANCE THERAPY:** Expenses for maintenance therapy of any type when the individual has reached the maximum level of improvement will not be considered eligible.
39. **MASSAGE THERAPY:** Expenses for massage therapy will not be considered eligible, unless when part of an overall patient treatment plan. Expenses for rolfing will not be considered eligible.
40. **MATERNITY:** Expenses for maternity expenses incurred by a dependent other than an employee's spouse will not be considered eligible.
41. **MEDICALLY NECESSARY:** Expenses which are determined not to be Medically Necessary will not be considered eligible.
42. **MISSED APPOINTMENTS:** Expenses for completion of claim forms, missed appointments or telephone consultations will not be considered eligible.
43. **NO LEGAL OBLIGATION:** Expenses for services which are furnished under conditions which the Covered Person has no legal obligation to pay will not be considered eligible. This exclusion will not apply to eligible expenses which may be covered by state Medicaid coverage where federal law requires this Employer's plan to be primary.
44. **NOT PERFORMED UNDER THE DIRECTION OF A PHYSICIAN:** Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.
45. **NOT RECOMMENDED BY A PHYSICIAN:** Expenses by a Hospital or covered residential treatment center if hospitalization is not recommended or approved by a legally qualified Physician will not be considered eligible.
46. **NUTRITIONAL SUPPLEMENTS:** Expenses for nutritional supplements, special infant formulas, or other enteral supplementation will not be considered eligible, unless received in an Inpatient Hospital environment, or as prescribed by a Physician, or as specified under **Eligible Medical Expenses**. Equipment used to administer nutritional supplements or other enteral supplementation may be covered by the Plan.
47. **OBESITY:** Expenses for weight loss programs or treatment of obesity will not be considered eligible, except for Morbid Obesity (see **Definitions**).

48. **OPERATED BY THE GOVERNMENT:** Expenses for treatment at a facility owned or operated by the government will not be considered eligible, unless the Covered Person is legally obligated to pay. This does not apply to covered expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related Illness or Injury.
49. **OUTSIDE THE UNITED STATES:** Expenses for services or supplies if the Covered Person leaves the United States, the U.S. Territories, or Canada for the express purpose of receiving medical treatment will not be considered eligible.
50. **OVER-THE-COUNTER MEDICATION:** Expenses for any over-the-counter medication will not be considered eligible. Expenses for drugs and medicines not requiring a prescription by a licensed Physician and not dispensed by a licensed pharmacist will not be considered eligible.
51. **PRIOR TO EFFECTIVE DATE:** Expenses incurred prior to the effective date of coverage, or after the termination date of coverage will not be considered eligible.
52. **RADIOACTIVE CONTAMINATION:** Expenses incurred as the result of radioactive contamination or the hazardous properties of nuclear material will not be considered eligible.
53. **RECREATIONAL AND EDUCATIONAL THERAPY:** Expenses for recreational and educational therapy; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; aquatic or pool therapies will not be considered eligible. Diabetic education is considered eligible as specified under **Eligible Medical Expenses**. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of ADD, ADHD or autism.
54. **REFRACTIVE ERRORS:** Expenses for radial keratotomy, lasik surgery or any surgical procedure to correct refractive errors of the eye will not be considered eligible.
55. **ROUTINE CARE:** Expenses for well child care and routine care, including x-ray and laboratory tests, vaccinations and immunizations will not be considered eligible, except as specified under **Eligible Medical Expenses**.
56. **SELF-INFLICTED INJURY:** Expenses for Injury or Illness arising out of attempted suicide or an intentional self-inflicted Injury, will not be considered eligible. This exclusion will not apply if self-inflicted injuries result from a medical condition such as depression and the benefits for such injuries are normally covered under the Plan.
57. **SEX TRANSFORMATION:** Expenses for care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change will not be considered eligible. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
58. **SEXUAL DYSFUNCTION:** Expenses for services, supplies or drugs related to sexual dysfunction not related to organic disease will not be considered eligible. Expenses for sex therapy will not be considered eligible.
59. **SHIPPING/HANDLING:** Expenses for mailing and/or shipping and handling expenses or sales tax will not be considered eligible.
60. **SLEEP DISORDERS:** Expenses for care and treatment for sleep disorders will not be considered eligible unless deemed Medically Necessary.
61. **STERILIZATION:** Expenses for elective sterilization or the reversal thereof will not be considered eligible.
62. **SUBSTANCE USE DISORDER:** Inpatient and outpatient treatment and detoxification services for Substance Use Disorder will not be considered eligible.
63. **TRAVEL:** Expenses for travel will not be considered eligible, except ambulance services as specified under **Eligible Medical Expenses**.
64. **USUAL AND CUSTOMARY CHARGE:** Expenses in excess of the Usual or Customary Charge will not be considered eligible.

65. **VITAMINS:** Expenses for vitamins, minerals and food supplements will not be considered eligible, except as prescribed by a Physician.
66. **VOCATIONAL TESTING:** Expenses for vocational testing or training will not be considered eligible.
67. **WAGE OR PROFIT:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for wage or profit (including self-employment) will not be considered eligible.
68. **WAR:** Expenses for the treatment of Illness or Injury resulting from war or any act of war, whether declared or undeclared, or while in the armed forces of any country or international organization will not be considered eligible.
69. **WEEKEND ADMISSION:** Expenses for care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or Saturday will not be considered eligible, unless surgery is scheduled within twenty-four (24) hours.
70. **WORKER'S COMPENSATION:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Covered Person would be entitled to compensation under any Worker's Compensation Law or occupational disease law or similar legislation will not be considered eligible.

Expenses for Injuries or Illness which were eligible for payment under Worker's Compensation or similar law and have reached the maximum reimbursement paid under Worker's Compensation or similar law will not be eligible for payment under this Plan.

## DEFINITIONS

The following defined terms are capitalized and used throughout the document:

**ADVERSE BENEFIT DETERMINATION:** Means any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A termination of benefits; or
4. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

**AMBULATORY SURGICAL FACILITY:** An ambulatory surgical center, free-standing surgical center, or outpatient surgical center, which is not part of a Hospital and which: (1) has an organized medical staff of Physicians; (2) has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; (3) has continuous Physician's services and registered graduate nursing (R.N.) services whenever a patient is in the facility; (4) is licensed by the jurisdiction in which it is located; and (5) does not provide for overnight accommodations.

**AUTHORIZED REPRESENTATIVE:** A Claimant may authorize a representative to act on their behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The Claimant must authorize the representative in writing, and this written authorization must be provided to the Plan. The Plan will recognize this Authorized Representative when the Plan receives the written authorization. In the case of a claim involving urgent care, a Health Care Professional with knowledge of the Claimant's medical condition is also permitted to act as the Claimant's Authorized Representative.

**BIRTHING CENTER:** A place licensed as such by an agency of the state. If the state does not have any licensing requirements, it must meet all of the following tests: (1) primarily engaged in providing birthing services for low risk pregnancies; (2) operated under the supervision of a Physician; (3) has at least one registered nurse (R.N.) certified as a nurse midwife in attendance at all times; (4) has a written agreement with a licensed ambulance for that service to provide immediate transportation of the Covered Person to a Hospital as defined herein if an emergency arises; and (5) has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

**CALENDAR YEAR:** January 1 through December 31 each year.

**CLAIM FOR BENEFITS:** A request for a plan benefit or benefits made by a claimant in accordance with a Plan's reasonable procedure for filing benefit claims. A claim for benefits includes any Pre-Service and Post-Service Claims. A request for benefits includes a request for coverage determination, for pre-authorization or approval of a plan benefit, or for a utilization review determination in accordance with the terms of the Plan.

**CLAIMANT:** A person requesting benefits under the Plan. A Claimant may or may not be a Covered Person under the Plan.

**CLOSE RELATIVE:** A Covered Person's spouse, parent (including step-parents), sibling, child, grandparent or in-law.

**CO-INSURANCE:** The percentage of eligible expenses the Plan and the Covered Person are required to pay. The amount of Co-insurance a Covered Person is required to pay is the difference from what the Plan pays as shown in the **Schedule of Benefits**.

**CO-PAY:** The portion of the medical expense which is the responsibility of the Covered Person as shown in the **Schedule of Benefits**. A Co-pay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible, Co-insurance, or Out-of-Pocket Limit.

**CONCURRENT CARE:** Ongoing care or course of treatment.

**CONTRACT ADMINISTRATOR:** The organization providing services to the Employer in connection with the operation of this Plan and performing such other functions, including processing of claims, as may be delegated to it.

**COSMETIC SURGERY:** Any procedure which is primarily directed at improving an individual's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

**COVERED EMPLOYEE:** An Eligible Employee whose coverage has become effective and has not terminated.

**COVERED PERSON:** An Eligible Employee or Eligible Dependent whose coverage has become effective and has not terminated.

**CREDITABLE COVERAGE:** Coverage provided under any Qualified Health Plan.

**CUSTODIAL CARE:** Care or service which is designed primarily to assist a Covered Person, whether or not disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

**DEDUCTIBLE:** The total amount of eligible expenses, as shown in the **Schedule of Benefits**, which must be incurred by a Covered Person during any Calendar Year before covered expenses are payable under the Plan. The Family Deductible maximum, as shown in the **Schedule of Benefits**, is the maximum amount which must be incurred by the covered family members during a Calendar Year. However, each individual in a family is not required to contribute more than one individual Deductible amount to the family Deductible.

*Carry-Over.* If the medical Deductible is satisfied in whole or in part by eligible expenses incurred during October, November or December, those expenses will apply to the Deductible applicable in the next Calendar Year.

*Common Accident.* If two (2) or more covered family members suffer Injuries from the same accident, only one Deductible will be applied to all charges incurred for the treatment of those Injuries during the same Calendar Year.

**DENTIST:** An individual who is duly licensed to practice dentistry or to perform oral surgery in the state where the service is performed and is operating within the scope of such license. A physician will be considered a Dentist when performing any covered dental services allowed within such license.

**DURABLE MEDICAL EQUIPMENT:** Equipment prescribed by the attending Physician which meets all of the following requirements: (1) is ordered by a Physician; (2) can withstand repeated use; (3) is not disposable; (4) is not useful in the absence of an Illness or Injury; (5) would have been covered if provided in a Hospital; and (6) is appropriate for use in the home.

**ELIGIBILITY DATE:** The first date of coverage after the Eligible Employee has satisfied any applicable waiting period. See **Eligibility & Enrollment** section.

**ENROLLMENT DATE:** The earlier of: (1) the first date of coverage; or (2) the first day of any applicable waiting period. The Enrollment Date with regards to a Late Enrollee (dependents) will be the first date of coverage.

**EXPERIMENTAL/INVESTIGATIONAL:** A drug, device, medical treatment or procedure is Experimental or Investigational: (1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; (2) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing Phase I, II or III clinical trials, or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; (3) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

“Reliable Evidence” shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or another facility studying substantially the same drug, device, medical treatment or procedure.

This definition will not apply to any treatment the Covered Person is receiving that is the only treatment available and/or is considered standard of care and does not violate church doctrine.

**EXTENDED CARE FACILITY:** An institution or that part of any institution which operates to provide convalescent or nursing care which: (1) is primarily engaged in providing to Inpatients skilled nursing care and related services for patients who require medical or nursing care; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons; (2) has policies which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more Physicians and one or more registered nurses (R.N.) to govern the skilled

nursing care and related medical or other services it provides; (3) has a Physician, a registered nurse (R.N.), or a medical staff responsible for the execution of such policies; (4) has a requirement that the health care of every patient be under the supervision of a Physician, and provides for having a Physician available to furnish necessary medical care in case of emergency; (5) maintains clinical records on all patients; (6) provides twenty-four (24) hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed above, and has at least one registered nurse (R.N.) employed full-time; (7) provides appropriate methods and procedures for the dispensing and administering of drugs and injections; (8) in the case of an institution in any state in which state or applicable local law provides for the licensing of institutions of this nature, is licensed pursuant to such law, or is approved by the agency of the state or locality responsible for licensing institutions of this nature as meeting the standards established for such licensing; and (9) meets any other conditions relating to the health and safety of individuals who are furnished services in such institutions or relating to the physical facilities thereof.

**GENETIC INFORMATION:** Information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes. Genetic Information will not be taken into account for purposes of (1) determining eligibility for benefits under the Plan (including initial enrollment and continued eligibility), (2) establishing contribution or premium accounts for coverage under the Plan, and (3) applying the Pre-Existing Condition rule under the Plan.

**HEALTH CARE PROFESSIONAL:** A Physician or other Health Care Professional licensed, accredited, or certified to perform specified health services consistent with State law.

**HOME HEALTH CARE AGENCY:** A public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions, it: (1) is duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services; (2) qualifies as a Home Health Care Agency under Medicare; (3) meets the standards of the area-wide health care planning agency; (4) provides skilled nursing services and other services on a visiting basis in the patient's home; (5) is responsible for administering a home health care program; and (6) supervises the delivery of a home health care program where the services are prescribed and approved in writing by the patient's attending Physician.

**HOSPICE:** An agency that provides counseling and incidental medical services and may provide room and board to terminally ill individuals and which meets all of the following requirements: (1) it has obtained any required state or governmental Certificate of Need approval; (2) it provides twenty-four (24) hour-a-day, seven (7) days-a-week service; (3) it is under the direct supervision of a duly qualified Physician; (4) it has a nurse coordinator who is a registered nurse (R.N.) with four (4) years of full-time clinical experience, at least two (2) of which involved caring for terminally ill patients; (5) it has a social-service coordinator who is licensed in the jurisdiction in which it is located; (6) it is an agency that has as its primary purpose the provision of hospice services; (7) it has a full-time administrator; (8) it maintains written records of services provided to the patient; (9) its employees are bonded, and it provides malpractice and malplacement insurance; (10) it is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; (11) it provides nursing care by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed physical therapist, certified occupational therapist, American Speech Language and Hearing Association certified speech therapist, or a certified respiratory therapist; and (12) it provides a home health aide acting under the direct supervision of one of the above persons while performing services specifically ordered by a Physician.

**HOSPITAL:** A facility which: (1) is licensed as a Hospital where licensing is required; (2) is open at all times; (3) is operated mainly to diagnose and treat illnesses or injuries on an Inpatient basis; (4) has a staff of one or more Physicians on call at all times; (5) has twenty-four (24) hour a day nursing services by registered nurses (R.N.'s); and (6) has organized facilities for major Surgery.

However, an institution specializing in the care and treatment of Mental Disorders which would qualify as a Hospital, except that it lacks organized facilities on its premises for major Surgery, shall be deemed a Hospital.

In no event shall "Hospital" include an institution which is primarily a rest home, a nursing home, a clinic, an Extended Care Facility, a convalescent home or a similar institution.

The definition of "Hospital" shall be expanded to include those services rendered to priest by the following facilities: (a) Guest House; (b) St. Luke's Institute; (c) St. John's Vianney; (d) Ridgeview Institute of Atlanta, or others as approved by the Archbishop or his designee.

**ILLNESS:** A disease, sickness, pregnancy or a condition involving bodily or mental disorder of any kind. All disorders which exist simultaneously and are due to the same or related causes shall be considered one Illness.

**INJURY:** A bodily Injury which results independently of Illness and is caused by accidental means. All bodily Injuries sustained in any one accident and all related conditions and recurrent symptoms will be considered one Injury.

**INPATIENT:** Admission as a bed patient to an eligible institution.

**LATE ENROLLEE:** An Eligible Dependent who does not elect coverage under this Plan within thirty-one (31) days of their Eligibility Date and who is not otherwise considered a Special Enrollee.

**LIFETIME MAXIMUM:** The maximum benefit payable during an individual's lifetime while covered under this Plan. Benefits are available only when an individual is eligible for coverage under this Plan. The Plan provides for a Lifetime Maximum Benefit for specific types of medical treatment as well as for the total benefits provided by the Plan as shown in the medical and prescription drug **Schedule of Benefits**.

**MEDICAL EMERGENCY:** Medical services and supplies provided after the sudden onset of a medical condition (Injury or Illness) manifesting itself by acute symptoms, including intense pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following: (1) the patient's health would be placed in serious jeopardy; (2) bodily function would be seriously impaired; or (3) there would be serious dysfunction of a bodily organ or part.

**MEDICALLY NECESSARY:** The medical service a patient receives which is recommended by a Physician and is required to treat the medical symptoms of a certain Illness or Injury. Although the service may be prescribed by a Physician, that does not mean the service is Medically Necessary. The medical care or treatment must: (1) be consistent with the medical diagnosis and prescribed course of medical treatment for the Covered Person's medical condition; (2) be required for reasons other than the convenience of the Covered Person or the attending Physician; (3) generally be accepted as an appropriate form of care for the medical condition being treated; and (4) be likely to result in physical improvement of the patient's medical condition which is unlikely to ever occur if the medical treatment is not administered.

**MENTAL DISORDER:** Means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services.

**MORBID OBESITY:** A diagnosed condition in which the body weight exceeds the medically recommended weight by either one hundred (100) pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

**ORTHODONTIC TREATMENT:** The corrective movement of teeth to treat a handicapping malocclusion of the mouth.

**OUT-OF-POCKET LIMIT:** An Out-of-Pocket Limit is the maximum amount of Co-insurance a Covered Person and/or all family members will pay for eligible expenses incurred during a Calendar Year before the covered percentage increases to 100%.

**NOTE:** Expenses incurred for the following cannot be applied toward the Out-of-Pocket Limit: (1) Co-pays; (2) Deductibles; (3) any penalty amounts; and (4) any charges as defined in the **General Exclusions and Limitations** section.

**PHYSICIAN:** A legally licensed Physician who is acting within the scope of their license, and any other licensed practitioner required to be recognized for benefit payment purposes under the laws of the state in which they practice and who is acting within the scope of their license. The definition of Physician includes, but is not limited to: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Chiropractor, Licensed Consulting Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Occupational Therapist, Optometrist, Ophthalmologist, Physical Therapist, Podiatrist, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Speech Therapist, Speech Pathologist, Licensed Midwife. An employee of a Physician who provides services under the direction and supervision of such Physician will also be deemed to be an eligible provider under the Plan.

**PLAN ADMINISTRATOR:** The Employer, which is sponsoring this Plan for its employees. The Plan Administrator may hire persons or firms to process claims and perform other Plan connected services.

**POST-SERVICE CLAIM:** Post-Service Claims are all claims that are not Pre-Service Claims.

**PREFERRED PROVIDER NETWORK:** All participating providers, health professionals, Hospitals, or other organizations having an agreement with Aetna ASA the Preferred Provider Organization (PPO).

**PRE-SERVICE CLAIM:** Pre-Service Claim is any request for approval of a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical or dental care.

**QUALIFIED HEALTH PLAN:** The following will be considered Qualified Health Plans: (1) a group health plan; (2) health insurance coverage; (3) Medicare; (4) Medicaid; (5) TRI-CARE; (6) an Indian Health Service plan or tribal organization plan; (7) a state risk pool coverage; (8) a federal employees health insurance coverage; (9) a public health plan (this includes plans established or maintained by a state, the U.S. government, a foreign country, a state or federal penitentiary, U.S. Veterans Administration, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the Plan); (10) a Peace Corps plan; (11) the State Children's Health Insurance Program.

**REHABILITATION FACILITY:** The facility must meet all of the following requirements: (1) must be for the treatment of acute Injury or Illness; (2) is licensed as an acute rehabilitation facility; (3) the care is under the direct supervision of a Physician; (4) services are Medically Necessary; (5) services are specific to an active written treatment plan; (6) the patient's condition requires skilled nursing care and interventions which cannot be achieved or managed at a lower level of care; (7) twenty-four (24) hour nursing services are available; and (8) the confinement is not for Custodial Care or maintenance care.

**SPECIAL ENROLLEE:** If an employee is declining enrollment for dependent coverage because of other health coverage under a Qualified Health Plan, the employee may in the future be able to enroll for dependent coverage, provided the request for enrollment is received within thirty-one (31) days after coverage under the Qualified Health Plan terminates due to one or more of the following:

1. Loss of eligibility, which includes, but is not limited to:
  - (a) Legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be considered an Eligible Dependent under the plan), death of an employee, termination of employment, reduction in the number of hours of employment;
  - (b) Coverage is offered through an HMO or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual);
  - (c) Coverage is offered through an HMO or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
  - (d) When a plan no longer offers any benefits to a class of similarly situated individuals, i.e. terminated coverage for part-time employees, etc.;
  - (e) When a Covered Person incurs a claim that would meet or exceed a lifetime limit on all benefits (this right continues until at least 31 days after the earliest date that a claim is denied due to the operation of the lifetime limit);
  - (f) The spouse's employer offers an open enrollment period at which time the spouse declines coverage under their employer-sponsored plan (termination of coverage must occur during an open enrollment period).
2. Termination of employer contributions toward the cost of coverage; or
3. COBRA continuation coverage is exhausted.

If an employee has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may be able to enroll for dependent coverage, provided the employee requests enrollment within thirty-one (31) days after the marriage, birth, adoption or placement for adoption of a new dependent child.

A written waiver of coverage stating the existence of coverage under another Qualified Health Plan must have been completed by the employee in order for the employee or dependent to be considered a Special Enrollee at a later date. A Special Enrollee is not considered a Late Enrollee.

The Pre-Existing Condition Limitation and Creditable Coverage provisions will apply to Covered Persons over age nineteen (19).

## **Special enrollment due to coverage under Medicaid or under a State Children's Health Insurance Program (CHIP)**

If an employee or eligible dependent did not enroll in the Plan when initially eligible, but was otherwise eligible to enroll, they will be permitted to later enroll in the Plan under one of the following circumstances:

1. The employee or eligible dependent was covered under Medicaid or CHIP at the time of initial enrollment and such coverage subsequently terminates; or
2. The employee or eligible dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP subsequent to the time they were initially eligible.

The employee or dependent must request enrollment in the Plan within sixty (60) days after coverage under Medicaid or CHIP terminates or within sixty (60) days after their eligibility for a premium assistance subsidy under Medicaid or CHIP is determined, whichever is applicable.

**SUBSTANCE USE DISORDER:** Means any disease or condition that is classified as a Substance Use Disorder in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services.

**SURGERY:** Any operative or diagnostic procedure performed in the treatment of an Illness or Injury by an instrument or cutting procedure through any natural body opening or incision. The reduction of a fracture or dislocation will also be considered Surgery.

**URGENT CARE CLAIM:** Any Pre-Service Claim for medical or dental care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or in the opinion of a Physician with knowledge of the Claimant's medical or dental condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A Post-Service Claim is never an Urgent Care Claim.

**URGENT CARE FACILITY:** A facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse, and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Facility, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition.

**USUAL AND CUSTOMARY CHARGE:** Charges made for medical or dental services or supplies essential to the care of the individual will be subject to a Usual and Customary determination. Usual and Customary allowances are based on what is usually and customarily accepted as payment for the same service within a geographical area. In determining whether charges are Usual and Customary, consideration will be given to the nature and severity of the condition and any medical or dental complications or unusual circumstances which require additional time, skill or experience.

**VISION MATERIALS:** Lenses, frames, and contacts.

## TERMINATION OF BENEFITS

An employee's or dependent's coverage shall terminate at the earliest time indicated below:

1. In the event the employee fails to make any required contributions when due, benefits shall automatically terminate at the end of the period for which the contribution was made.
2. Upon termination of employment or retirement, benefits will cease on the day the employee terminated or retired.
3. The date the employee ceases to be eligible for coverage or ceases to be in a class eligible for coverage.
4. The date the dependent ceases to be eligible for coverage or ceases to be in a class eligible for coverage.
5. The date the dependent becomes an Eligible Employee.
6. When the employee or Eligible Dependent (other than a Dependent Child) of the employee enters military service on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year.
7. The date the employee or dependent (or any person seeking coverage on behalf of the employee or dependent) performs an act, practice, or omission that constitutes fraud.
8. The date the employee or dependent (or any person seeking coverage on behalf of the employee or dependent) makes an intentional misrepresentation of a material fact.
9. The date the Plan is terminated.

### RETROACTIVE TERMINATION OF COVERAGE

Except in cases where an employee or other Covered Person fails to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan for any Covered Person unless the Covered Person (or a person seeking coverage on behalf of that person) performs an act, practice, or omission that constitutes fraud with respect to the Plan, or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least thirty days advance written notice to each Participant or dependent who would be affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where required employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

### FAMILY AND MEDICAL LEAVE ACT (FMLA)

An eligible employee that qualifies for FMLA is entitled to a maximum of twelve (12) weeks of unpaid leave in any twelve (12) month period for reasons that qualify under FMLA. The employee must have worked for the Employer for at least twelve (12) months, and have worked at least 1,250 hours during the twelve (12) months preceding the start of the leave.

The National Defense Authorization Act (NDAA) expands FMLA to include leaves for military families. A spouse, son, daughter, parent, or next of "kin" will be allowed up to twenty-six (26) weeks during a twelve (12) month period to care for a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious Injury or Illness.

An employee may choose not to retain health coverage during the FMLA leave. However, when an employee returns from leave, the employee is entitled to have coverage reinstated on the same basis as it would have been if the leave had not been taken. Coverage will be reinstated without any additional qualification requirements imposed by the Plan. (The Plan's provisions with respect to Pre-Existing Conditions, Deductibles and Coinsurance amounts will apply on the same basis as they did prior to the FMLA leave.)

The Employer may offer FMLA payment options as follows: (1) in advance; (2) as the FMLA leave goes along; or (3) upon return to active work. However, under item number (1), payments in advance, may not be the only option offered.

## **UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)**

If an individual was covered under this Plan immediately prior to being called to active duty by any of the uniformed services of the United States of America, coverage may continue for up to twenty-four (24) months or the period of uniformed service leave, whichever is shortest, if the individual pays any required contributions toward the cost of coverage during the leave. If the leave is less than thirty (30) days, the contribution rate will be the same as for active employees. If the leave is longer than thirty (30) days, the required contribution will not exceed 102% of the cost of coverage.

Whether or not the individual elects continuation coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA), coverage will be reinstated on the first day the individual returns to active employment with the Employer if released under honorable conditions and the individual returns to employment: (a) on the first full business day following completion of the military service for a leave of thirty (30) days or less; or (b) within fourteen (14) days of completing military service for a leave of thirty-one (31) to one hundred eighty (180) days; or (c) within ninety (90) days of completing military service for a leave of more than one hundred eighty (180) days ( a reasonable amount of travel time or recovery time for an Illness or Injury determined by the VA to be service connected will be allowed).

When coverage under this Plan is reinstated, all provisions and limitations in this Plan will apply to the extent that they would have applied if the military leave had not been taken and coverage had been continuous under this Plan. The eligibility waiting period will be waived and the Pre-Existing Condition Limitation will be credited as if you had been continuously covered under this Plan from the original effective date. (This waiver of limitations does not provide coverage for any Illness or Injury caused or aggravated by the military service, as determined by the VA. For complete information regarding the rights under USERRA contact the Employer.)

## **BENEFITS EXTENSION PROGRAM**

If a Covered Person's coverage ceases due to termination of employment, reduction in hours, death of the employee, or the dependent child ceases to meet the dependent requirements; and the Covered Person has been covered under the Plan for at least six (6) consecutive months and is not eligible for Medicare or any other group coverage, benefits may continue for a maximum period not to exceed six (6) months with payment of the appropriate contribution. This election must be made and the contribution paid within thirty-one (31) days of termination of coverage.

In addition, if the employee terminates coverage at sixty (60) or older, benefits can be extended to age sixty-five (65) or entitlement to Medicare, if no other coverage is available.

If health coverage is provided to a qualified beneficiary after a qualifying event without regard to Extension of Benefits continuation coverage (e.g. as a result of the Uniformed Services Employment and Reemployment Rights Act of 1994), Extension of Benefits continuation coverage will run concurrently with the other health coverage. In other words, the maximum period of Extension of Benefits continuation coverage will continue to be measured from the date of the qualifying event, regardless of whether other alternative coverage is provided.

While continued, coverage will be that which was in force on the last day worked as an active employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

### **PRIEST, RELIGIOUS AND SEMINARIAN COVERAGE**

In the event that Priest, Religious or Seminarians are unable to perform full and all duties for the Archdiocese, the coverage will continue, without any interruption, providing the Priest, Religious and Seminarians maintain their status with the Archdiocese.

### **CONTINUATION OF PARTICIPATION FOR EMPLOYEES RECEIVING DISABILITY BENEFITS**

Employees participating in the Plan who become disabled and who are eligible for benefits under the Long Term Disability Income Plan may continue participation during all or a portion of the period of their disability. During the period of continued participation, the employee's eligible dependents may also continue participation as long as dependent contributions are paid.

The maximum period that participation may continue depends on the length of continuous service of the employee at the onset of the disability:

CONTINUOUS FULL-TIME SERVICE	MAXIMUM CONTINUATION OF PARTICIPATION
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Less than 1 year	6 months
1 but fewer than 5 years	12 months
5 but fewer than 10 years	24 months
10 or more years	36 months

Except as otherwise provided in the section of Extension of Benefits, participation will end immediately if one of the following occurs:

1. The participant becomes ineligible to receive disability income plan payments;
2. Coverage terminates as a result of termination of the Plan or modification of the Plan;
3. Applicable contributions are not paid in a timely fashion (if any).

This period of continuation coverage will run concurrently and will be applied toward satisfaction of any of the Extension of Benefits provisions.

Disabled participants may be entitled to receive Medicare benefits. In this event, the Plan will remain primary.

## COORDINATION OF BENEFITS

If a Covered Person is covered under more than one Plan as defined below, including this Plan, benefits will be coordinated. The benefits payable under this Plan for any Claim Determination Period, will be either its regular benefits or reduced benefits which, when added to the benefits of the other Plan, may equal 100% of the Allowable Expenses defined below.

### DEFINITIONS

**Allowable Expenses:** Any Medically Necessary, Usual and Customary item of expense incurred by a Covered Person which is covered at least in part under this Plan.

**Claim Determination Period:** A Calendar or Plan Year or that portion of a Calendar or Plan Year during which the Covered Person for whom a Claim is made has been covered under this Plan.

**Plan:** For purposes of this Coordination of Benefits section and the Reimbursement Rights section, Plan shall mean any plan or policy under which benefits or services are provided by:

1. Group, blanket or franchise insurance coverage;
2. Any group Hospital service prepayment, group medical or dental service prepayment, group practice or other group prepayment coverage;
3. Group coverage under labor-management trustee plans, union welfare plans, Employer organization plans or employee benefits plans;
4. Coverage under Medicare and any other governmental program that the Covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary;
5. Coverage provided through a school or other educational institution;
6. Coverage under any Health Maintenance Organization (HMO);
7. Coverage provided by no-fault auto insurance, by whatever name it is called, when not prohibited by law; or
8. Coverage provided by Worker's Compensation.

When medical or dental payments are available under vehicle insurance, this Plan shall pay excess benefits only, without reimbursement for vehicle Plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal Injury protection) coverage with the auto carrier.

### ORDER OF BENEFIT DETERMINATION

When a Covered Person is covered by this Plan and another Plan, the Plans will coordinate benefits when a Claim is made.

When a Claim is made, the Plan that pays first (or the primary Plan) will pay as if there were no other Plan involved. A Plan that does not include a coordination of benefits provision may not take the benefits of another Plan into account when it determines benefits.

The secondary Plan may take the benefits of another Plan into account only when it is secondary to that Plan. The secondary Plan will adjust its benefits so that the total benefits paid by both Plans will not exceed 100% of the Allowable Expenses. Neither Plan pays more than it would without the Coordination of Benefits provision.

1. The benefits of the Plan which covers the individual as an employee (that is, other than as a dependent) are determined before those of the Plan which covered the individual as a dependent.

2. The rules for the order of benefits for a dependent child when parents are not separated or divorced are as follows:
  - (a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year where the word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.
  - (b) If both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.
  - (c) If the other Plan does not have the rules described above relating to the parents' birthday, but instead has a rule based upon the gender of the parent, and the Plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.
3. If the Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - (a) First, the Plan of the parent with custody of the child;
  - (b) Then, the Plan of the spouse of the parent with the custody of the child;
  - (c) Then, the Plan of the parent not having custody of the child.
  - (d) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the secondary Plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
  - (e) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined above.
4. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and the Plans do not agree on the order of benefits, this rule is ignored.
5. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee longer are determined before those of the Plan which covered that person for the shorter term. To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the person was eligible under the second Plan within twenty-four hours after the first ended. The start of a new Plan does not include a change in the amount or scope of a Plan's benefits, a change in the entity which pays, provides or administers the Plan's benefits, or a change from one type of Plan to another (such as, from a single employer plan to that of a multiple employer plan).

When there is a conflict in the Plans' Coordination of Benefit rules, this Plan will never pay more than 50% of allowable charges when paying as the secondary Plan.

This Plan will not pay first if the Covered Person would have been eligible under another primary Plan but for the failure of the Covered Person to meet the technical requirements of the other Plan (such as obtaining pre-authorization). In that instance, this Plan shall pay as if it were the secondary Plan, but in no event shall this Plan pay more than 50% of the allowable charges.

Coordination of Benefits may operate to reduce the total amount of benefits otherwise payable during any claim determination period with respect to a Covered Person under this Plan. When the benefits of this Plan are reduced, each benefit is reduced proportionately. The reduced amount is then charged against any applicable benefit limit of this Plan.

When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an Allowable Expense and a benefit paid.

## **RECOVERY**

If the amount of the payment made by this Plan is more than it should have been due to lack of information or error, or should have been paid by another Plan, the Contract Administrator, on behalf of the Plan, has the right to recover the amount paid from one or more of the following:

1. The person this Plan has paid;
2. The Covered Person;
3. Providers of care;
4. Insurance companies;
5. Other organizations; or
6. Another Plan.

## **PAYMENT TO OTHER CARRIERS**

Whenever payments, which should have been made under this Plan in accordance with the above provisions, have been made, this Plan will have the right to pay any organization making those payments any amounts it determines to be warranted in order to satisfy the intent of the above provisions. Amounts paid in this manner will be considered to be benefits paid under this Plan and, to the extent of these payments, this Plan will be fully discharged from liability.

## EFFECT OF MEDICARE

In accordance with Federal Medicare regulations, the following is a brief explanation of the Medicare guidelines, not to be considered all inclusive.

1. **Working Aged Benefits**

*Employers with 20 or more Employees:* This Plan will be primary when an active employee or spouse is age sixty-five (65) and over.

2. **Disabled Employees/Spouses**

*Employers with 100 or more Employees:* This Plan will be primary when an active employee or dependent is disabled and covered by Medicare.

3. **Disability Due to End Stage Renal Disease (ESRD)**

For employees or dependents under age sixty-five (65), if Medicare eligibility is due solely to End Stage Renal Disease (ESRD), the Plan will be primary only during the first thirty (30) months of Medicare coverage. Thereafter, the Plan will be secondary with respect to Medicare coverage.

If an employee or dependent is under age sixty-five (65) when Medicare eligibility is due solely to ESRD, and the individual attains age sixty-five (65), the Plan will be primary for a full thirty (30) months (or 33 months, depending upon whether a transplant or self-dialysis is involved) from the date of ESRD eligibility. Thereafter, Medicare will be primary and the Plan will be secondary.

If an employee or dependent is age sixty-five (65) and over, working and develops or is undergoing treatment for ESRD, the Plan will be primary for a full thirty (30) months (or 33 months from the date of ESRD eligibility). Thereafter, Medicare will be primary and the Plan will be secondary.

4. **All Individuals Eligible for Medicare**

Covered Persons should be certain to enroll in Medicare Part A & B coverage in a timely manner to assure maximum coverage. Contact the Social Security Administration office to enroll for Medicare. If this Plan is secondary, benefits under this Plan will be coordinated with the dollar amount that Medicare will pay, subject to the rules and regulations specified by federal law.

## REIMBURSEMENT RIGHTS

Benefits are payable only upon the Covered Person's acceptance of the terms of the Plan. As a condition to receiving benefits under this Plan, a Covered Person agrees to provisions of the following Reimbursement Rights.

1. **Responsible Party:** For purposes of this Reimbursement Rights section, Responsible Party means any party actually, possibly or potentially responsible for making any payment to a Covered Person due to an Injury, Illness, or condition. This also includes any other Plan (as defined under Coordination of Benefits), person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, Worker's Compensation, other insurance policies for funds any insurance coverage, or the liability insurance for such party.
2. **Constructive Trust:** By accepting benefits from this Plan, the Covered Persons agree to serve as a constructive trustee, and to hold in constructive trust such money or property resulting from any payments or settlement proceeds from any Responsible Party. Further, the Covered Persons agree that they will not dissipate any such money or property without prior written consent of this Plan, regardless of how such money or property is classified or characterized, from any Responsible Party. Failure to hold such funds in trust will be deemed a breach to the Plan.
3. **Reimbursement:** In addition, if this Plan has already paid benefits to the Covered Person (or other providers on their behalf) for any Injury or Illness where a Responsible Party has a legal obligation to compensate the Covered Person for his or her Injury or Illness, this Plan has a right of reimbursement for such payments.
4. **Cooperation:** The Covered Person agrees to refrain from releasing any Responsible Party or funds that may be liable for or obligated to the Covered Person for the Injury, Illness, or condition without obtaining this Plan's written approval. By participating in this Plan, the Covered Person automatically agrees to (a) promptly execute any documents and instruments, including a reimbursement agreement, and take any action that this Plan considers necessary to protect its rights; (b) not take any actions that could jeopardize or prejudice this Plan's position or rights (including refraining from making any settlement or recovery that attempts to reduce or recover or exclude the full cost of all benefits provided by this Plan); and (c) notify this Plan within thirty (30) days following the date any notice is given to any party of the Covered Person's intention to pursue or investigate a Claim due to Injury, Illness, condition, or other loss.
5. **Recovery from Covered Person:** If the Covered Persons fail to reimburse this Plan for any benefits paid or to be paid, as a result of said Illness, Injury or condition, out of any recovery or reimbursement received, the Covered Person will be liable for any and all expenses (whether fees or costs) associated with this Plan's attempt to recover such money from the Covered Person.
6. **Lien Rights:** This Plan will automatically have a lien to the extent of benefits paid by this Plan for the treatment of the Illness, Injury, or condition, and other losses for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise, including from any Responsible Party or insurance coverage related to treatment for any Illness, Injury, or condition for which this Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by this Plan including, but not limited to, the Covered Person; any Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by this Plan.
7. **Applicability to All Settlements and Judgments:** This shall apply and this Plan is entitled to recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the benefits this Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than expenses paid by this Plan.
8. **Rights under State Law:** By accepting benefits under this Plan, each Covered Person acknowledges that this Plan may enforce these provisions under Georgia statutes and other state laws relating to contract theory, constructive trust, constructive lien, or other equitable theory under state common law.
9. **Interpretation:** The Plan Administrator retains sole and final discretion for interpreting the terms and conditions of this Plan document. The Plan Administrator may amend this Plan in its sole discretion at any time without notice. This right of reimbursement shall bind the Covered Person's guardian(s), estate, executor, personal representative, and heir(s).

## **RIGHTS OF RECOVERY**

In the event of any overpayment of benefits by this Plan, the Plan will have the right to recover the overpayment. If a Covered Person is paid a benefit greater than allowed in accordance with the provisions of this Plan, the Covered Person will be required to refund the overpayment. If payment is made on behalf of a Covered Person to a Hospital, Physician, or other provider of health care, and the payment is found to be an overpayment, the Plan will request a refund of the overpayment from the provider. If the refund is not received from the provider, or from the Covered Person, the amount of the overpayment will be deducted from future benefits, if available. If future benefits are not available, the Covered Person will be required to refund the overpayment.

## **RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION**

For the purposes of implementing the terms of this Plan, the Contract Administrator retains the right to request any medical or dental information from any insurance company or provider of service it deems necessary to properly process a claim. The Contract Administrator may, without consent of the Covered Person, release or obtain any information it deems necessary. Any person claiming benefits under this Plan shall furnish to the Contract Administrator such information as may be necessary to implement this provision.

## GENERAL PROVISIONS

### NOTICE OF CLAIM

Written notice of a claim and all information needed to process the claim must be given to the Contract Administrator as soon as reasonably possible and in no event, later than one year from the date such claim is incurred.

### RECORDS

For the purposes of claims administration, each Covered Person authorizes and directs any provider that has attended, examined, or treated them to furnish to the Contract Administrator, at any time upon its request, any and all information, records or copies of records relating to the attendance, examination or treatment rendered to the Covered Person; and the Contract Administrator agrees that such information and records will be considered confidential. Further, any charges imposed relative to the acquisition of such information will be absorbed by the Covered Person, except as specified in the **Schedule of Medical Benefits**.

### CLAIM DETERMINATION

**Urgent Care Claims:** Determination for any pre-service Urgent Care Claims (whether adverse or not) must take place as soon as possible but not longer than seventy-two (72) hours, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such failure, the Contract Administrator shall notify the Claimant as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. The Contract Administrator shall notify the Claimant of the Plan's benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of:

1. The Plan's receipt of the specified information; or
2. The end of the period afforded the Claimant to provide the additional information.

Urgent Care Claims must be decided within seventy-two (72) hours. There is no extension of time allowed for claims involving urgent care.

**Pre-Service Claims:** Pre-Service Claims must be decided within a maximum of fifteen (15) days at the initial level and up to thirty (30) days following an Adverse Benefit Determination. In the case of a failure by a Claimant or an Authorized Representative of a Claimant to follow the Plan's procedures for filing a Pre-Service Claim, the Claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a Claim for Benefits. This notification shall be provided to the Claimant or Authorized Representative, as appropriate, as soon as possible, but not later than five (5) days following the failure. Notification may be oral, unless written notification is requested by the Claimant or Authorized Representative.

**Post-Service Claims:** Post-Service Claims must be decided within thirty (30) days for the initial decision and a maximum of sixty (60) days on review.

**Filing Extensions:** The Plan may extend determination on both Pre-Service and Post-Service Claims for one additional period of fifteen (15) days after expiration of the relevant initial period, if the Contract Administrator determines that such an extension is necessary for reasons beyond the control of the Plan. Delays caused by cyclical or seasonal fluctuations in claims volume are not considered to be matters beyond the control of the Plan that would justify an extension.

If the reason for taking the extension is the failure of the Claimant to provide necessary information, the time period for making the determination is tolled from the date on which notice of the necessary information is sent to the Claimant until the date on which the Claimant responds to the notice. The time periods for making a decision are considered to commence to run when a claim is filed in accordance with the reasonable filing procedures of the Plan, without regard to whether all the information necessary to decide the claim accompanies the filing.

**Concurrent Care Decisions:** If a Plan has approved an ongoing course of treatment to be provided over a period of time, or number of treatments, any reduction or termination by the Plan (other than by plan amendments or termination) before the end of such period of time or number of treatments shall be considered an Adverse Benefit Determination. The Contract Administrator shall notify the Claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments for a claim involving urgent care, shall be decided as soon as possible, taking into account the medical or dental exigencies, and the Contract Administrator shall notify the Claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

**Adverse Benefit Determination:** The notice of an Adverse Benefit Determination will either include the protocol in which it was based upon or a statement that a protocol was relied upon and that a copy is available free of charge upon request by the Claimant.

Notification of an Adverse Benefit Determination (at both the initial level and on review) based on medical or dental necessity, experimental treatment, or other similar exclusion or limit will be explained as to the scientific or clinical judgement of the Plan to the Claimant's medical or dental circumstances, or an explanation will be provided free of charge to the Claimant upon request.

Where the Plan utilizes a specific internal rule or protocol, it must furnish the protocol to the Claimant or their Authorized Representative upon request.

**Authorized Representative:** The Plan will recognize an Authorized Representative, including a health care provider, acting on behalf of a Claimant. The Plan will recognize a Health Care Professional with knowledge of a Claimant's medical or dental condition as the Claimant's representative in connection with an Urgent Care Claim. Procedures will be established by the Plan for verifying that an individual has been authorized to act on behalf of a Claimant.

#### **RIGHT OF REVIEW AND APPEAL**

A Claimant has up to one hundred eighty (180) days to file an appeal of an Adverse Benefit Determination. As part of the appeal process, a Covered Person has the right to (a) review this Plan and other relevant documents, (b) argue against the denial in writing, and (c) have a representative act on behalf of the Covered Person in the appeal. All relevant documents will be provided free of charge, upon request by the Claimant, after receiving an Adverse Benefit Determination. A document, record or other information is considered relevant if it was relied upon in making the benefit determination, if it was considered or generated in the course of making the benefit determination, if it demonstrates compliance with the administrative processes, or if it constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the determination.

If the Claimant or an Authorized Representative appeals an Adverse Benefit Determination, the Contract Administrator will respond to the appeal within seventy-two (72) hours for an Urgent Care Claim, thirty (30) days for a Pre-Service Claim, and sixty (60) days for a Post-Service Claim. The notice will specify the reason for the denial or describe the additional information required to process the claim. Written denial will include:

1. Specific reasons for denial with reference to the Plan Document section(s);
2. A description and need for any other material pertinent to the claim; and
3. An explanation of this Plan's review procedure and the names of any medical or dental professionals consulted as part of the claims process.

A full and fair review of an Adverse Benefit Determination will be performed by an appropriate named fiduciary, who is neither the party who made the initial adverse determination, nor the subordinate of such person. The review will not defer to the initial Adverse Benefit Determination. The review will take into account all comments, documents, records, and other information submitted by the Claimant, without regard to whether such information was previously submitted or considered in the initial determination.

If the review results in another Adverse Benefit Determination, it shall include specific reasons for denial, written in a manner understandable to the Covered Person, and will contain specific reference to the pertinent Plan provisions upon which the decision was based.

A Covered Person must follow the Right of Review and Appeal procedures listed above before initiating any legal actions. These are the Covered Person's administrative remedies, which must be exhausted before legal action may be pursued.

If the Plan fails to provide procedures in compliance with the regulation, or the required procedures, the Claimant is deemed to have exhausted the administrative remedies and is free to pursue legal action on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

All requests for review of initially denied claims (including all relevant information) must be submitted to the following address:

Meritain Health, Inc.  
Appeals Department  
P. O. Box 1380  
Amherst, NY 14226-1380

#### **PLAN INTERPRETATION**

All decisions concerning the interpretation or the application of this Plan and its terms, shall be at the discretion of the Plan Administrator.

#### **PERIODIC REPORT**

Within one month following the date of any change in the group of employees and dependents covered, the Employer shall furnish the Contract Administrator the names of all employees who have become covered or cease to be covered since the date of the previous reports.

Failure on the part of the Employer to report the name of any employees or dependents who are eligible for coverage, shall not deprive such persons of their benefits under the Plan; nor shall failure on the part of the Employer to report any termination of any employee or dependent, obligate the Plan to continue such benefits beyond the date of termination.

#### **CHOICE OF PHYSICIAN**

The Covered Person shall have the free choice of any legally qualified Physician and the Physician-patient relationship shall be maintained.

#### **AFFILIATED COMPANIES**

Any of the Employer's affiliates, subsidiaries, or divisions may be deleted or added to the Plan upon written notice by the Employer on or before the date such deletion or addition is effective.

#### **CONTRIBUTIONS**

Dependent participation in this Plan is entirely voluntary. The Employer reserves the right to modify the amount of any contributions.

#### **INSPECTION OF PLAN DOCUMENT**

Upon request, the Employer shall make this Plan Document available for inspection by any Covered Person at a reasonably accessible place.

#### **AMENDMENT OR TERMINATION OF THE PLAN**

The Plan may be amended or terminated at any time without prior notice.

It is the intent of this Plan to comply with all applicable laws.

## INSTRUCTIONS FOR SUBMISSION OF CLAIMS

All claims submitted should include all of the following:

1. Employee's name, identification number, and home address.
2. If claim is made for a dependent, the dependent's name, Employer and age.
3. Employer's name and group number.
4. Name and address of the Physician or Hospital.
5. Physician's diagnosis.
6. Itemization of charges.
7. Date the Injury or Illness began.
8. Drug bills (not cash register receipts) showing RX number, name of drug, date prescribed, and name of person for whom drug is prescribed.

### Claims Processing Procedures:

Acceptable claims forms, bills and/or documents:

1. HCFA/UB or ADA Dental Claim Forms; or
2. Superbills - any submitted claim form with all of the following information:
  - (a) Detail of procedure performed
  - (b) Detailed breakdown of charges
  - (c) Diagnosis
  - (d) Date of service
  - (e) Federal Tax Identification Number (TIN) and address of provider

A claim submitted with all of the above information included will be processed, unless additional information is required to complete the claim. Additional information that may be required to process a claim may include, but is not limited to the following:

1. Coordination of Benefits - Other Insurance Coverage
2. Extension of Benefits
3. Parental custody
4. Legal responsibility for dependent child health coverage
5. Divorce decree
6. Medicare eligibility
7. Certificate of Creditable Coverage
8. Medical or dental history information
9. Injury or accident information.

When the Contract Administrator receives a billing with the required information, the Contract Administrator will process it in accordance with the time frames for Post-Service Claims, Pre-Service Claims and Urgent Care Claims, and in accordance with all other Plan provisions, and in accordance with eligibility and claim information on file. The Contract Administrator will provide a notice of benefit determination or a notice of Adverse Benefit Determination to the Covered Person's designated address.

Please direct all questions regarding claims to:

Meritain Health<sup>SM</sup>  
P.O. Box 27267  
Minneapolis, MN 55427-0267  
(952) 546-0062  
(800) 925-2272

Please direct all claims to the address shown on the ID card.

Every attempt will be made to help Covered Persons understand their benefits; however, any statement made by an employee of the Employer or the Contract Administrator will be deemed a representation and not a warranty. Actual benefit payment can only be determined at the time the claim is submitted and all facts are presented in writing.

If a definite answer to a specific question is required, please submit a written request, including all pertinent information, and a statement from the attending Physician (if applicable), and a written reply (which will be kept on file) will be sent.

# USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

## SECTION 1 - USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

This Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

1. Determination of eligibility;
2. Coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual's claim);
3. Coordination of Benefits;
4. Adjudication of health benefit claims (including appeals and other payment disputes);
5. Establishing employee contributions;
6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
7. Billing, collection activities and related health care data processing;
8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
9. Obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance);
10. Medical Necessity reviews or reviews of appropriateness of care or justification of charges;
11. Utilization review, including pre-authorization, concurrent review and retrospective review;
12. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security Number, payment history, account number and name and address of the provider and/or health plan); and
13. Reimbursement to the Plan.

Health care operations include, but are not limited to, the following activities:

1. Quality assessment;
2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
3. Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);
5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
7. Business management and general administrative activities of the Plan, including, but not limited to:
  - (a) Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; or
  - (b) Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
8. Resolution of internal grievances; and
9. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

## **SECTION 2 - THE PLAN WILL USE AND DISCLOSE PHI AS REQUIRED BY LAW AND AS PERMITTED BY AUTHORIZATION OF THE INDIVIDUAL**

With an authorization, the Plan will disclose PHI to the benefit plans or other separate plans of this Employer. However, if such other plan(s) are HIPAA-covered entities that are part of an organized health care arrangement with the Plan, an authorization is not required in order for the Plan to disclose PHI to the other plan for the other Plan's health care operations or for the health care operations of the organized health care arrangement.

## **SECTION 3 - FOR PURPOSES OF THIS SECTION, THE EMPLOYER IS THE PLAN SPONSOR**

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions.

## **SECTION 4 - WITH RESPECT TO PHI, THE PLAN SPONSOR AGREES TO CERTAIN CONDITIONS**

The Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the plan document or as required by law;
2. Ensure that any agents, including a subcontractor and the Contract Administrator, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
5. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
6. Make PHI available to an individual in accordance with HIPAA's access requirements;
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. Make available the information required to provide an account of disclosures;
9. Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the plan's compliance with HIPAA;
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
11. Ensure that adequate separation set forth below is established.

## **SECTION 5 - ADEQUATE SEPARATION BETWEEN THE PLAN AND THE PLAN SPONSOR MUST BE MAINTAINED**

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

1. The Director of Human Resources and the Benefits Manager or other authorized representative of the Plan; and/or
2. Staff designated by the Director of Human Resources and the Benefits Manager as may be appropriate from time to time.

## **SECTION 6 - LIMITATIONS OF PHI ACCESS AND DISCLOSURE**

The persons described in Section 5 may only have access to and use and disclose PHI for plan administration functions that the Plan Sponsor performs for the Plan.

## **SECTION 7 - NONCOMPLIANCE ISSUES**

If the persons described in Section 5 do not comply with this plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

## **SECTION 8 – SECURITY OF ELECTRONIC PHI**

To the extent required by 45 C.F.R. section 164.314(b), except when the only electronic PHI disclosed to the Plan Sponsor is disclosed pursuant to 45 C.F.R. section 164.504(f)(1)(ii) or iii), or as authorized under 45 C.F.R. section 164.508, the Plan Sponsor will reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan.

In accordance with the foregoing, the Plan Sponsor shall:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
2. Ensure that the adequate separation required by 45 C.F.R. section 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
4. Report to the Plan any security incident of which it becomes aware.

## **Section 9 - Health Information Technology for Economic and Clinical Health (HITECH) Act**

The Plan will comply with all applicable requirements of final Regulations issued by the Department of Health and Human Services pursuant to Subtitle D of the HITECH Act and any authoritative guidance issued pursuant to that Act, if and as they become applicable to the Plan. If there is any conflict between the requirements of Subtitle D of the HITECH Act, and any provision of this Plan, applicable law will control. Any amendment or revision or authoritative guidance relating to Subtitle D of the HITECH Act is hereby incorporated into the Plan as of the date that the Plan is required to comply with such guidance.



**AMENDMENT #1**  
**to the**  
**THE ROMAN CATHOLIC ARCHDIOCESE OF ATLANTA**  
**GROUP HEALTH CARE PLAN**  
**Group No. 10974**

This Amendment describes changes to The Roman Catholic Archdiocese of Atlanta Group Health Care Plan effective January 1, 2011. **These changes are effective as of January 1, 2011** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document. Please contact the Plan Administrator identified in the Plan Document if you have any questions regarding the changes described in this Amendment.

The Roman Catholic Archdiocese of Atlanta (the "Plan Administrator") is amending the The Roman Catholic Archdiocese of Atlanta Group Health Care Plan (the "Plan") as follows:

*The "Physician Office Visits" and "Routine Care" benefits in the **Schedule of Medical Benefits – Value Plan** are hereby deleted and replaced with the following:*

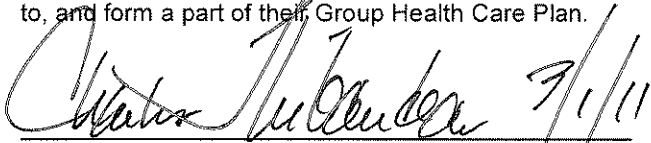
<b>SCHEDULE OF MEDICAL BENEFITS VALUE PLAN</b>				
<b>MEDICAL BENEFITS</b>	<b>PPO PROVIDERS</b>		<b>NON-PPO PROVIDERS (Subject to Usual &amp; Customary Charges)</b>	
	<b>Plan Pays</b>	<b>Covered Person Pays</b>	<b>Plan Pays</b>	<b>Covered Person Pays</b>
<i>Physician Office Visits</i>	100%	\$25 Co-pay; Deductible waived	60%	40% after Deductible
X-ray and Lab Services Performed in a Physician's Office	100%	\$0	60%	40% after Deductible
<i>Routine Care</i> (age 17 and over)	100%	\$25 Co-pay; Deductible waived	No Coverage	N/A
X-ray and Lab Services Performed in a Physician's Office	100%	\$0		

The "Physician Office Visits" and "Routine Care" benefits in the **Schedule of Medical Benefits – Premier Plan** are hereby deleted and replaced with the following:

SCHEDULE OF MEDICAL BENEFITS PREMIER PLAN				
MEDICAL BENEFITS	PPO PROVIDERS		NON-PPO PROVIDERS (Subject to Usual & Customary Charges)	
	Plan Pays	Covered Person Pays	Plan Pays	Covered Person Pays
<b>Physician Office Visits</b>	100%	\$20 Co-pay; Deductible waived	70%	30% after Deductible
X-ray and Lab Services Performed in a Physician's Office	100%	\$0	70%	30% after Deductible
<b>Routine Care</b> (age 17 and over)	100%	\$20 Co-pay; Deductible waived	No Coverage	N/A
X-ray and Lab Services Performed in a Physician's Office	100%	\$0		

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, The Roman Catholic Archdiocese of Atlanta has caused this Amendment to take effect, be attached to, and form a part of their Group Health Care Plan.

  
 Authorized Signature \_\_\_\_\_ Date 7/1/11

  
 Title \_\_\_\_\_

  
 Witness \_\_\_\_\_ Date 3-1-2011

  
 Title \_\_\_\_\_